

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD  
TASK FORCE ON MENTAL HEALTH

Arlington, Virginia  
Tuesday, December 19, 2006

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P R O C E E D I N G S

2  
3 LTG KILEY: Good morning, and welcome to  
4 this session of the DOD Task Force on Mental  
5 Health. For those of you who were not here  
6 yesterday, this is a congressionally mandated task  
7 force asked to look into the current military  
8 mental-health system. The overall intent of our  
9 meeting here today is to gain insight into that  
10 system and ultimately provide Congress with  
11 recommendations for areas of improvement, but also  
12 to acknowledge areas that are flourishing and  
13 doing well. We have asked specific speakers to  
14 present to the task force because we are  
15 particularly interested in their programs and  
16 experience.

17 I would like first to go around the room  
18 and introduce ourselves for those who were not  
19 here yesterday.

20 COL CAMPISE: Good morning. I am Rick  
21 Campise. I am a pediatric psychologist. I work  
22 for the Air Force Surgeon General as the Chief of

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1 Deployment Behavioral Health.

2 MS. FRYAR: Good morning. I am Deborah  
3 Fryar and I am the family member representative on  
4 the task force.

5 COL DAVIES: I am Colonel Jeff Davies,

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and I am the alternate government official for

this meeting.

LTG KILEY: I am Dr. Kevin Kiley, the  
Army Surgeon General, Commander, MEDCOM

DR. MCCORMICK: I am Dr. Dick McCormick.  
I am a clinical psychologist and one of the  
civilian members.

CAPT MACEACHERN: I am Captain Margaret  
MacEachern (?), a Navy child and adolescent  
psychiatrist.

MS. POWER: Kathryn Power, Director of  
the Center for Mental Health Services at the  
Department of Health and Human Services.

LTC DOUGLAS: I am Lieutenant Colonel  
John Douglas, Headquarters, Marine Corps Manpower  
and Reserve Affairs.

DR. MACDERMID: I am Shelley MacDermid.

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I am an associate dean in the College of Consumer  
and Family Sciences at Purdue University.

DR. ZEISS: I am Dr. Antoinette Zeiss.  
I am the Deputy Chief Consultant for the Office of  
Mental Health Services in VA, and I am VA  
representative to the task force.

COL ORMAN: My name is Dr. Dave Orman.  
I am an academic psychiatrist and I have traveled  
full-time in support of the task force.

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LCDR WERBEL: I am Dr. Aaron Werbel. I  
11 am a clinical psychologist and the Behavioral  
12 Health Affairs Officer at Headquarters, Marine  
13 Corps.  
14 CAPT KLAM: I am Dr. Warren Klam. I am  
15 the Navy Psychiatry Special Leader.  
16 COL PEREIRA: I am Dr. Angela Pereira,  
17 social work representative to the task force.  
18 DR. MCCURDY: I am Layton McCurdy, and I  
19 am an adult psychiatrist and retired from the  
20 Medical University of South Carolina in  
21 Charleston.  
22 DR. BLAZER: Good morning. I am Dan

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1 Blazer, and I am a psychiatrist and epidemiologist  
2 at Duke University.  
3 LTG KILEY: Ms. Ellen Embrey who is the  
4 designed federal official for the task force's  
5 Parent Federal Advisory Board of the Defense  
6 Health Board has an unavoidable conflict and will  
7 not be able to attend this meeting. In her  
8 absence she has appointed Colonel Jeffery Davies,  
9 the Army Surgeon General's Executive Officer as  
10 the alternate designated official. Colonel  
11 Davies, would you like to call this open session  
12 of the task force to order?  
13 COL DAVIES: Yes, sir. As the acting

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14 designated federal official for the Defense Health  
15 Board, a federal advisory committee to the  
16 Secretary of Defense which serves as a continuing  
17 scientific body to the Assistant Secretary of  
18 Defense for Health Affairs and the Surgeons  
19 General of the military departments, I hereby call  
20 this meeting to order.  
21 LTG KILEY: Thank you much, Colonel  
22 Davies. Dr. Burke, do you have any administrative

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1 comments?  
2 DR. BURKE: Yes, sir. Thank you,  
3 General Kiley. Good morning to all, and welcome.  
4 Would all attendees remember to sign the general  
5 attendance roster on the table outside if you have  
6 not already done so? Remember that we will be  
7 transcribing the open session, so please use the  
8 microphones when speaking and clearly state your  
9 name. The transcripts will be published on the  
10 task force's Website within 90 days of this  
11 meeting. We would also like to ask you to be  
12 mindful of your fellow persons here and allow  
13 those who are speaking courtesy and respect.  
14 The restrooms are located outside the  
15 main door to the right, and if there are  
16 administrative requirements, please see Ms.  
17 Bennett who is at the table at the entrance, or

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18 Ms. Ferrell who is working audiovisual. Thank  
19 you, General Kiley.  
20 LTG KILEY: Thank you, Dr. Burke. I  
21 would like to turn this over now to my co-chair,  
22 Dr. MacDermid.

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1 DR. MACDERMID: Thank you very much,  
2 General Kiley, and welcome to our speakers and  
3 everyone else who is here this morning. We  
4 appreciate your time and effort very much.  
5 Our first speaker this morning is Mr.  
6 Jody Donahoo who is here to present on TRICARE  
7 Reserve Select.  
8 MR. DONAHOO: Good morning. I am  
9 delighted to be with you here this morning. I am  
10 overwhelmed as I go around the panel and hear you  
11 introduce yourselves, a very distinguished panel,  
12 and I would like to clarify that my Ph.D. is not  
13 clinical, it is policy and background, and  
14 although I have a clinical background in mental  
15 health, I am not a psychologist or whatever.  
16 In recent years, Congress has  
17 dramatically expanded the continuum of health  
18 coverage that is available to reserve members and  
19 their families. Today's presentation will place  
20 TRICARE Reserve Select in that continuum. Then we  
21 will zero in on TRICARE Reserve Select itself. I

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22 have tried to keep my remarks to under 10 minutes

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1 so I can allow plenty of time for your questions.  
2 Of note, when I refer to the reserve  
3 components throughout today's presentation, I mean  
4 all seven of the reserve components. The seven  
5 reserve components are the Army National Guard,  
6 the Army Reserve, the Navy Reserve, the Marine  
7 Corps Reserve, Air National Guard, Air Force  
8 Reserve, and the U.S. Coast Guard Reserve.  
9 However, my colleagues at the National Guard  
10 Bureau remind me frequently that the Guard is  
11 administered through 54 states and territories  
12 which certainly adds a level of complexity to  
13 them.  
14 I am going to be spending a little bit  
15 of time on this slide. I am going to go through  
16 the continuum of care and try to place TRICARE  
17 Reserve Select in that context. This table  
18 summarizes health care coverage for reserve  
19 component members in relationship to the active-  
20 duty status and whether or not the active duty is  
21 in support of a contingency operation. If you  
22 recognize, the middle column is activated for

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1 greater than 30 days. I will talk about the  
2 before, during, and after an activation time  
3 period.

4 Reserve component members are in an  
5 inactive duty status when performing drills or  
6 serving funeral honors. When in an inactive duty  
7 status or when activated for 30 days or less,  
8 members are covered for any injury, illness, or  
9 disease incurred or aggravated while in that duty  
10 status. This is often referred to line-of-duty  
11 care. Care is limited to the line-of-duty  
12 condition itself during that time period.

13 Then moving across to the preactivation  
14 column, and also notice in the rows, the first row  
15 is if the active duty is in support of a  
16 contingency operation, the bottom row is if the  
17 active duty is not in support of a contingency  
18 operation. That makes a real difference about  
19 their benefits.

20 Going across the first row, second  
21 column, is a member is issued delayed effective  
22 date active-duty orders to report to active duty

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1 in support of a contingency operation at a future

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date, then the member becomes eligible for MIF

services, that is, military, hospital, and clinic  
services, and TRICARE coverage the same as any  
other active-duty service member, or ADSM. This  
is limited for up to 90 days before the member is  
due to report to active duty. The member's family  
also becomes eligible for TRICARE at the same  
time. The member can check eligibility on the Web  
themselves through the Guard Reserve portal. That  
is key for them, because they can go and actually  
see the date they were made eligible, thereby they  
can be covered for TRICARE.

Then going to the middle column, when  
called or ordered to active duty for more than 30  
days, they become eligible the same as any active-  
duty service member, and their family, the same as  
any active-duty family member. Going across, if  
the member deactivates from active duty in support  
of a contingency operation for more than 30 days,  
the member and their family gets TRICARE coverage  
under the Transitional Assistance Management

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Program, or TAMP, for a period of 180 days. No  
premium is charged, but deductibles and cost  
shares of the active-duty family member rate does  
apply, and that applies for both the sponsor and  
their family.

6           Going across, if the member continues in  
7       the selected reserves, that is, the drilling  
8       reserves, after deactivation, the member may  
9       qualify to purchase coverage under TRICARE Reserve  
10      Select, and I will give you more details about  
11      that in a moment.

12           I want to go back and go across the  
13      bottom row, and it is fairly simple. If they are  
14      in an inactive duty status or active duty for less  
15      than 30 days and it is a noncontingency, they get  
16      line-of-duty care only. Going across, there is no  
17      preactivation benefit if the active duty is not in  
18      support of a contingency operation, but when they  
19      report to active duty, they get the same care or  
20      access as active-duty service members and their  
21      family, the same as active-duty family members.

22           Going across, when they are deactivated,

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1       they are not eligible for TAMP, but they could  
2       purchase coverage under the Continued Health Care  
3       Benefit Program, or CHCBP, that is for 18 months,  
4       and premiums are charged for that. But if they  
5       continue in the selected reserve, they could  
6       purchase coverage under TRICARE Reserve Select.

7           Let me move on to the next slide. There  
8       are two types of coverage under TRICARE Reserve  
9       Select, or TRS, TRS member only coverage, and TRS

10 member and family coverage. Congress froze the  
11 premiums at the 2006 rate through 30 September,  
12 2007, so we did not get an annual bump-up or  
13 increase these rates 1 January as it was  
14 scheduled. Currently, selected reserve members,  
15 selected reserve meaning those who are drilling,  
16 may qualify for one of three premium tiers.  
17 However, Congress changed this for FY 2008 by  
18 broadening the eligibility for Tier 1 so widely  
19 that they no longer need Tiers 2 and 3. Since  
20 this change is coming, I will only briefly  
21 describe the current three tiers.

22 For all three of the current tiers, the

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1 member must be in the selected reserve and must  
2 sign a service agreement to continue in the  
3 selected reserve. Members may qualify for Tier 1  
4 after serving on active duty in support of a  
5 contingency operation. Tier 2 is for members who  
6 are unemployment recipients, self-employed, or  
7 employees whose employer does not offer them a  
8 health plan. Tier 3 is for selected reserve  
9 members who do not qualify for either Tier 1 or  
10 Tier 2. We will continue to offer the three tiers  
11 through next September, and at that time they will  
12 all collapse into the 28 percent tier. That is  
13 the only tier that will remain at that time. The

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14 higher-cost tiers will be eliminated. Service  
15 agreements will no longer required after 1 October  
16 2007.  
17 There will be one inclusionary criteria  
18 and one exclusionary criteria. First, the reserve  
19 component member must be in the selected reserve.  
20 Second, the RC member cannot be eligible for the  
21 FEHB program, or the Federal Employees Health  
22 Benefit Program. We expect to be able to provide

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1 more details of the 2008 version of TRS this  
2 summer.  
3 We have three TRICARE regional  
4 contractors who serve as TRS, and I believe you  
5 will be hearing from contractors in the regions  
6 later on this morning. The TRICARE South regional  
7 contractor services those who reside in overseas  
8 areas.  
9 Billing and premium payment are very  
10 similar to any monthly bills that people get in  
11 their mailbox every month. Bills arrive early in  
12 the month and payments are typically due by the  
13 end of the month. Electronic payments can be  
14 established for TRS premium payments. Like most  
15 bills, TRS bills will give the member the  
16 opportunity to provide a change of address right  
17 on the bill itself.

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18 What do individuals get under TRICARE  
19 Reserve Select when they have purchased coverage?  
20 They receive TRICARE Standard and TRICARE Extra  
21 coverage on the same basis as active-duty family  
22 members. This includes space available access to

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1 military clinics and hospitals. TRICARE Prime is  
2 not available under TRICARE Reserve Select. The  
3 benefit is the same that active-duty family  
4 members get with one exception. They do not get  
5 the extended care health option, or ECHO, which is  
6 uniquely designed for families whose sponsor is  
7 actually on active duty. As you can see in the  
8 middle of this, the benefits for behavioral health  
9 care are the same as the benefits under TRICARE  
10 Standard and Extra for active-duty family members.  
11 There is no other difference. I believe that  
12 Capitan Buss from TMA may have spoken to you at  
13 earlier sessions, and I am not going to go into  
14 further detail about the benefit other than to say  
15 it is the same.

16 When covered individuals receive  
17 services outside MTFs, or military hospitals,  
18 their deductibles and cost shares are the same as  
19 active-duty family members under TRICARE Standard  
20 and Extra. If they use a TRICARE network  
21 provider, they pay TRICARE Extra cost shares. If

22 Washington DC 20061219 TF meeting transcripts FINAL.txt  
they use a nonnetwork TRICARE authorized provider,

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1 they pay TRICARE Standard cost shares. Remember,  
2 TRICARE Prime is not available under TRICARE  
3 Reserve Select.  
4 Tier 1 is continuously open to members  
5 after they deactivate from active duty in support  
6 of a contingency operation. Open season for Tiers  
7 2 and 3 closed last month. The participation in  
8 TRS has appeared to plateau somewhere between  
9 11,000 and 12,000 RC members purchasing coverage.  
10 In this slide, the way you read plans is that is  
11 the number of RC members who have purchased  
12 coverage. My numbers here also include together  
13 member-only coverage as well as member and family  
14 coverage. When you take all the covered lives  
15 into consideration, it is the 33,913 covered lives  
16 under a total of 11,778 plans, and these are the  
17 numbers as of last Friday.  
18 QUESTION: What is the total number  
19 eligible?  
20 MR. DONAHOO: Excellent question.  
21 Considering there are about 700,000 selected  
22 reserve members who could qualify, the take rate

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1 then is about 1.7 percent.

2 Under the current TRS program, all  
3 eligibility issues are steered toward the member's  
4 personnel offices or their reserve component.  
5 Issues of enrollment, customer service, and claims  
6 payment are steered toward the servicing TRICARE  
7 regional contractor.

8 Many tell us that they have found the  
9 TRICARE Reserve Select Website to be comprehensive  
10 and quite helpful. I encourage you if you are  
11 looking for additional details after the meeting  
12 to feel free to peruse the Website, and it has a  
13 lot of the details right there. It is written  
14 from the beneficiary or the reserve component  
15 perspective.

16 If you look at the column of links on  
17 the right, you will see that the first link is to  
18 the Guard and Reserve portal. Personnel will use  
19 that to actually record the service agreements and  
20 the member will actually go into the Guard Reserve  
21 portal and launch the TRS application to get their  
22 enrollment form. It is kind of nice the way the

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1 enrollment form is currently programmed. It is

2 kind of like TurboTax where you go through the  
3 application, answer the questions, and at the end  
4 of it you can print out a completed application  
5 with all the information typed right on it. That  
6 helps us reduce some of the errors as well.

7 Finally, always refer members to either  
8 the TRS Website, or the bottom one is Reserve  
9 Affairs. With that, I will be happy to take any  
10 questions.

11 COL ORMAN: Once you collapse things  
12 into Tier 1, the cheaper plan, what is the  
13 anticipation of the enrollment increase? Have any  
14 projections been made?

15 MR. DONAHOO: We are still in the  
16 process at this point of designing the program, so  
17 I do not have the estimates available. We  
18 typically do have an actuarial go through and  
19 calculate the take rate. What I can say is if you  
20 look at this particular one, you may want to go  
21 back to that slide if you may where the  
22 participation rates were, slide number -- if you

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19

1 look at this, Tier 1 has been up and going since  
2 April 2005, so we have about a year and a half  
3 experience. There are a number of qualifications  
4 that they have to meet which may have limited some  
5 participation, but beyond this slide, I hesitate

6

7 DR. ZEISS: What proportion of eligible  
8 reserve does that number represent?

9 MR. DONAHOO: About 700,000. There are  
10 approximately 830,000 in the selected reserves,  
11 there are several components of the reserves, and  
12 we are only talking about those who drill. When  
13 we back out the active guard reserve and those who  
14 are actually on active duty at any given day, it  
15 is about 700,000.

16 DR. MCCORMICK: Am I correct to  
17 understand then that the priority for a reservist  
18 would be the same as a family member, higher than  
19 a retiree going to the MTF?

20 MR. DONAHOO: Yes, sir. We actually  
21 have five access categories. They get the fourth  
22 access category which is the same as active-duty

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1 family members not enrolled in TRICARE Prime.

2 DR. MCCORMICK: One other question. If  
3 a member chose to go to a nonnetwork provider,  
4 what rate is that provider paid at?

5 MR. DONAHOO: He may charge up to our  
6 TRICARE maximum allowable charge or TMAC, a  
7 nonnetwork TRICARE authorized provider may charge  
8 up to 115 percent of the TMAC rate, and the  
9 family's cost share is 20 percent of the TMAC.

10 DR. MACDERMID: You said there were five

11 categories of access priority. Can you tell us  
12 what those are in order, please?

13 MR. DONAHOO: Certainly. Number one is  
14 active-duty service members. Number two is  
15 active-duty family members enrolled in TRICARE  
16 Prime. Number three is retirees and their  
17 families enrolled in TRICARE Prime. Number four  
18 is active-duty family members not enrolled in  
19 TRICARE Prime. And number five is all other  
20 beneficiaries of the military health system who  
21 are not enrolled in TRICARE Prime.

22 MS POWER: I am a member of the reserve

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1 component and one of the things I have found in  
2 communicating this program is that it has been  
3 very difficult to find out the right kind of  
4 communication and marketing strategies to get to  
5 the unit level and to get to the individual level.  
6 I think that somehow there is a difference. There  
7 is a difference in the way that TRICARE itself is  
8 communicated and marketed and how TRICARE Reserve  
9 Select is. Can you talk a little bit about some  
10 of the communication strategies for getting to the  
11 individual unit members of the reserve component?

12 MR. DONAHOO: Yes, ma'am. As you point  
13 out, it is a different strategy to marketing

14 TRICARE Reserve Select. The fundamental  
15 difference is the primary group that is  
16 responsible for getting the word out is Reserve  
17 Affairs and the reserve components. The reason  
18 why is because select reservists are not TRICARE  
19 beneficiaries when they are inactive. We do not  
20 know who they are, but the reserve components do  
21 know who they have in their units and drilling.  
22 So the primary responsibility for marketing does

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1 lie, or getting the word out, lies with the  
2 reserve components. Reserve Affairs interacts  
3 with the service MRAs, Manpower and Reserve  
4 Affairs assistant secretaries and promulgates  
5 policy to them, and then they go down the seven  
6 RCs and each RC has their own developed strategy  
7 for getting the word out through their ranks since  
8 they know how they are structured.

9 On the TRICARE side, our primary  
10 responsibility is to prepare the marketing  
11 materials, the Website is one of the best  
12 marketing materials we have, and make it available  
13 to the reserve component members and the RCs  
14 themselves for getting the word out.

15 MS. FRYAR: On slide 6, if you will turn  
16 to slide 6, I believe I heard you say that under  
17 TRICARE Reserve Select that the ECHO program is

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not available for this particular plan. Can you  
19 refresh us on what the exact coverage is for  
20 behavioral health care? I do see where it says  
21 includes partial hospitalization and residential  
22 treatment, and I think you said that the coverage

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1 under TRS is the same as Standard and Extra. Can  
2 you refresh us on specifically what is covered?  
3 MR. DONAHOO: Actually, what I  
4 understand is, first off, I am not the subject  
5 matter expert on the mental-health benefit itself.  
6 I have some experience with it, but I do not  
7 purport to be the TMA expert. I understand  
8 Captain Buss and Colonel Grissom have come and  
9 spoken to you all before, and I generally defer to  
10 them for the specifics.

11 I can say that it is viewed as an  
12 extremely comprehensive benefit, as I have heard,  
13 when you compare it to other plans. In  
14 particular, one that jumps out in my mind is the  
15 Residential Treatment Center benefit.  
16 Historically, as I have understood, very few  
17 health plans actually cover RTC benefits, but we  
18 have in my experience for over a decade, going  
19 back before I started with TRICARE in the early  
20 1990s.

21 DR. MACDERMID: Can you tell us about

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the procedures that you use for checking the lists

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1 of providers in your areas? How do you do that?  
2 How do you verify the lists of providers that you  
3 have in different areas?  
4 MR. DONAHOO: First off, our experts in  
5 TMA and the ones who have primary responsibility  
6 for the TRICARE network our are TRICARE regions,  
7 and I understand that the TRICARE regions are up  
8 this morning and will be speaking to you, so I  
9 would like to defer any of questions about network  
10 strategies and provider recruitment to the regions  
11 when they come up.  
12 As far as standard providers or TRICARE  
13 authorized nonnetwork providers, we have also been  
14 very interested in them as well and have several  
15 activities we have been doing in the last year or  
16 two to study them. Once again, I will defer to  
17 another expert who is appearing before you this  
18 afternoon. Mr. Mike O'Bar out of our office has  
19 been tasked as watching the adequacy of TRICARE  
20 Standard providers. As you know, many of the  
21 Reservists live in areas away from our military  
22 hospitals, and for many of those people, access to

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1 TRICARE is going to be through a nonnetwork  
2 provider, so we have been very interested in that.

3 DR. MACDERMID: And I will ask the  
4 question that we ask all our speakers, I know I am  
5 watching the time, too, don't worry.

6 MR. DONAHOO: As I see your next speaker  
7 behind me.

8 DR. MACDERMID: But we got a little  
9 ahead, so I am taking advantage. The question we  
10 have been asking a lot of speakers is if you could  
11 tell us what you would like us to recommend, what  
12 would you ask us to recommend?

13 MR. DONAHOO: Actually, in the area that  
14 I have spoken to you on today, TRICARE Reserve  
15 Select, I do not have any specific  
16 recommendations. However, I would like to pick up  
17 on one of the previous questions I had which has  
18 been probably our major challenge with TRICARE  
19 Reserve Select, getting the word out down through  
20 the Reserve components to the units to the actual  
21 members, so if there is any assistance that can be  
22 provided in getting word out to the Reservists.

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1 When we go to the one-tier approach, with very few

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2 qualifications, Congress essentially has opened up

3 TRICARE Reserve Select to virtually all Reservists  
4 except for the federal employees. So we would  
5 hope that everyone would understand that they have  
6 the choice and exercise the choice whether to buy  
7 or not buy.

8 DR. MACDERMID: Thank you very much.

9 MR. DONAHOO: Thank you. I am delighted  
10 to have been here today, and thank you for your  
11 questions.

12 (Applause)

13 DR. MACDERMID: Our next speaker is Dr.  
14 Jack Wagoner, and Lois Krysa I believe is here as  
15 well. Thank you very much for joining us, and we  
16 look forward to your remarks.

17 DR. WAGONER: Thank you. It is a  
18 pleasure being here. At the Board's pleasure I  
19 have a suggestion, though. Up here you cannot see  
20 the slides, so I recommend to actually put the  
21 podium down, so if there are walkers like myself  
22 you can at least see what slide you are on.

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1 I am Dr. Jack Wagoner, and I have the  
2 privilege of working with -- the people there are  
3 wonderful. I am invited by them to be part of  
4 this presentation and I am going to be the first  
5 part, and Ms. Lois Krysa is going to be the second

6  
7 DR. MACDERMID: Dr. Wagoner, you can use  
8 a mike down here if you would prefer.

9 DR. WAGONER: Also let me give you an  
10 invitation, I like to be interrupted, so I notice  
11 this is a spunky Board so please do that. I  
12 welcome interruptions, and then we will address  
13 them because questions as they come as important.

14 Let me tell you a little bit about  
15 myself, and I do this a little embarrassingly  
16 because I am not sure why, but a little bit of my  
17 credentials so you know what my thinking is and  
18 where I am coming from. I am retired military and  
19 I have 35 years of military service counting  
20 academy time and reserve time for medical school.  
21 I am a dual-trained psychiatrist, board-certified  
22 psychiatrist, I am a clinical psychologist, I am a

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1 licensed psychologist. I presently work for  
2 HealthNet, a managed care company, the contractor,  
3 and I am trilingual in that I speak military, I  
4 speak managed care, and I also am in private  
5 practice, so I speak as a practitioner which keeps  
6 me balanced.

7 This slide is to caveat to tell you a  
8 small point that you may not understand. Active-  
9 duty military personnel, you get most of their

10 treatment at the military facility which is  
11 understandable. If they go to civilian  
12 facilities, they essentially are funded by  
13 supplemental care. What that means is they get  
14 the full gamut of care and they are not  
15 constricted with the requirements they have for  
16 family members. There are fairly restrictive  
17 requirements which will make that point. They  
18 have intensive outpatient treatment, they have  
19 partial hospitalization, they have substance  
20 abuse/CD treatment for active-duty members.

21 When you step into active-duty member  
22 families, it is entirely different. If they get

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1 their care from the MTF which is a good thing, but  
2 more are getting it in the community just because  
3 the MTFs, military treatment facilities, are more  
4 restrictive and they have more needs, so more are  
5 being sent out to the network. If that is the  
6 case, there are restrictions which we will  
7 emphasize as we go through here. In particular,  
8 partial hospitalizations and intensive outpatient  
9 programs. Many are not covered either because of  
10 statute or by the restrictions for their  
11 certification. There is adult care in the general  
12 sense available. There is a limitation for child  
13 and adolescents. That is the area that is most

14 hurting and most in demand. I would like to make  
15 a point here, too, about providers. Most of us  
16 think of providers, unless you are in the managed  
17 care arena and if you think this way you are  
18 advanced, as individuals, but providers are also  
19 institutions. They could be programs, they could  
20 be other areas or hospitals. The individual  
21 providers end up being TRICARE friendly. As I  
22 talk to providers, they usually tell me they want

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1 to do TRICARE not because it is beneficial in  
2 terms of finances, many times it is not, but it is  
3 because they have a heart for the military. The  
4 institution also has a heart, but not quite as  
5 liberal. They look at the bottom line which is  
6 appropriate, and many times they are not as  
7 flexible as individual providers.

8 Here is the breakout of exactly who is  
9 purchasing care, 6 percent retired, 5 percent  
10 active duty, twenty-three percent of nonactive-  
11 duty family members, and you can see two large  
12 chunks, active-duty family members greater than  
13 18, and an extremely large chunk of active-duty  
14 family members 17 and less. Together that is  
15 about two-thirds of the purchased care.

16 This slide is remarkable because it is  
17 absent a provider. It is just one example. It is

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18 for RTC, a residential treatment center, any  
19 residential treatment center within 100 miles.  
20 This happens to be Fairfax. But if you put in  
21 PHP, partial hospital programs, or IOPs which are  
22 not covered, you see the same blank in terms of

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1 providers available because there are limited  
2 providers for a number of reasons which we will  
3 emphasize.  
4 TRICARE coverage, and this might be a  
5 little bit pedantic making this point, but it is  
6 an important point, covered by statute and  
7 regulation. A statute is simply a bill that is  
8 put into law and we are required to follow that,  
9 and indeed we do. Title 10 of the U.S. Code is the  
10 statute. Once you have a statute, often there are  
11 experts that get together and put together the  
12 regulations to define that. That is the C.F.R.,  
13 Code of Federal Regulation. The institutions that  
14 usually work with that TMA, TR0 and others, they  
15 actually have a policy and that is application to  
16 the C.F.R. The reason I am making this point is  
17 because if there are changes, and this is an  
18 optimistic time, policy may take 6 months. You  
19 might say that that is optimistic, but yes.  
20 C.F.R. changes may take 18 months, an optimistic  
21 change. Statute changes can be as long as 3

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22 years. So it takes time and it takes sometimes

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1 leverage to address that. The Mental Health  
2 Parity Act of 1996 emphasizes an important point,  
3 that mental health has parity with physical  
4 health. That ran for 5 years and then is renewed  
5 every year. It is due to be renewed this year if  
6 Congress so desires.

7 Here is a graphic demonstration. You  
8 can see the number on the side of the slides. It  
9 is 500. In comparison with commercial, we took an  
10 example of MHN which is the sister network in  
11 HealthNet, the commercial available facilities for  
12 chemical dependencies, and you can see the  
13 difference. For IOPs, a huge different. Half-day  
14 partials, full-day partials, a difference. It is  
15 pretty much similar for inpatient, meaning that  
16 TRICARE has a number of certified inpatient fairly  
17 equal to the commercial side.

18 This is available psychiatric programs.  
19 Remember that the previous was chemical  
20 dependency, and notice the scale is 1,200. Again  
21 you see the dramatic difference. TRICARE have a  
22 huge number of inpatient units because that is

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1     what we use. It is quite a bit larger than our  
2     sister network MHN because they do not need to use  
3     as many inpatient units. They clearly stepped  
4     down to PHPs, half PHPs, and IOPs. Since we do  
5     not have those available functionally or  
6     specifically, what happens is we use inpatient  
7     units. They are more costly, and when the time  
8     comes to step down it is more difficult. I can  
9     tell you a generic case of what happens to me  
10    almost every day. A 30 year old female who has a  
11    substance, a behavioral health problem and is  
12    bipolar and is inpatient hospitalized. Her  
13    husband has just left her. She is pregnant. Her  
14    kids have been taken away. She does not inpatient  
15    standards and it comes to me to see what should I  
16    do about stepping down. She is too fragile to  
17    step down so I authorize a short extension so she  
18    can get the disposition plan in order before she  
19    goes to outpatient. If I were on the commercial  
20    side I would probably step down to probably a full  
21    PHP, then a half PHP, and then an IOP.

22                   LCDR WERBEL: Dr. Wagoner?

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1                   DR. WAGONER: Yes?

2 LCDR WERBEL: If I might interrupt since  
3 you offered that opportunity.  
4 DR. WAGONER: The offer is there.  
5 LCDR WERBEL: If it makes good business  
6 sense from the bottom line and it is clinically  
7 indicated, why do we not have them available if  
8 they are available in the commercial world?  
9 DR. WAGONER: It is in statute. What I  
10 mean is that the requirements are in statute and  
11 the definition of what we need in partial  
12 hospitalization programs, there is a history  
13 behind this, that if makes it more restrictive to  
14 use PHPs, and IOPs by statute are generally not  
15 approved. This was done in 1993 and it was done  
16 very consciously. This is not 1993, this is 2006.  
17 DR. MCCURDY: Do I sense this might be a  
18 recommendation on your part?  
19 DR. WAGONER: You are a very perceptive  
20 man.  
21 DR. MACDERMID: May I ask one more  
22 question?

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1 DR. WAGONER: Please.  
2 DR. MACDERMID: You said the statutory  
3 restrictions were placed by conscientiously and  
4 thoughtfully. What was the rationale? Do you  
5 know?

6 DR. WAGONER: This back in 1993, and  
7 there is a little bit of history and it is a  
8 little fuzzy, so I will give you my best  
9 rendition. At the time, PHPs were overused. That  
10 might be a kind way of saying it. So Congress  
11 restricted and made it very clear about what the  
12 requirements were, which was a good thing then.  
13 Now the restrictions cause most provider PHPs to  
14 not want to do it both because of the financial  
15 remuneration is low, and because the restrictions  
16 are too high. I cannot really tell you what the  
17 providers tell me about this requirement because  
18 they say things that I cannot repeat on the  
19 record. They are very specific, and we scratch  
20 our heads also. Again, Congress did a good job in  
21 1993, but this is 2006.

22 DR. MCCORMICK: Maybe you can answer

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1 this. We have heard from providers as well, one  
2 being the additional accreditation which does not  
3 seem to offer any additional value. I guess maybe  
4 you cannot even say if you agree with that. We  
5 have heard from providing organizations that they  
6 already go out and get JCH or CARPA accreditation,  
7 and to get into your system they have to get an  
8 additional accreditation which of course is an  
9 issue.

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DR. WAGONER: Correct.

11 DR. MCCORMICK: Let me ask another

12 related question though. We understand that on

13 the medical side and not the mental-health side,

14 TRICARE has the option of changing the benefit

15 based on advances in technology or advances in

16 care, but that that is one of the issues that --

17 mental health does not have that option and that

18 is an example of why they cannot change and add

19 IOP. Is that your understanding as well?

20 DR. WAGONER: The short answer is yes.

21 As you make recommendations, I agree

22 wholeheartedly, and new innovations must be

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1 considered because otherwise you get a very good

2 decision restricted for that time, and as time

3 goes on there are many things that just cannot

4 anticipate, and that would be a very important

5 point.

6 DR. MCCORMICK: I don't know how to ask

7 this question, but we have heard concerns about

8 the payment rates, and while I personally applaud

9 the patriotism of some providers to be willing to

10 take families at a rate that is below market, it

11 hardly seems fair that active-duty members and

12 their families should have to rely on that

13 patriotism. Do you have any data or is it your

15 TRICARE is in line or not in line with what other  
16 behavioral health providing plans are paying?

17 DR. WAGONER: As a generalization, it is  
18 considerably lower, and perhaps we can give some  
19 numbers later. I am at your disposal not just  
20 now, afterwards or even after today. I will be  
21 here tomorrow if you would like to use me.

22 MS. KRYSA: I am Lois Krysa. I am

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1 quality manager from the TRICARE Regional Office  
2 North, and I am going to reinforce the points that  
3 you all on the committee have just made very well.

4 If we look at the continuum of health  
5 care for behavioral health in the industry we see  
6 that there are outpatient visits, intensive  
7 outpatient therapy, partial hospitalization  
8 programs, full-day partial hospitalization  
9 programs, and inpatient care availability. The  
10 problem we have in TRICARE which has been very  
11 well expressed, we do not have the option of  
12 having intensive outpatient programs, it is not  
13 part of the TRICARE benefit.

14 We do have half-day partial  
15 hospitalization programs and we do have full-day  
16 hospitalization programs. The difficulty that we  
17 have is that we have very few of those facilities

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18 available to our TRICARE beneficiaries. This is  
19 not a really common problem between all the three  
20 regions with TRICARE, and you will probably hear  
21 that in your presentations from West and South.  
22 We in the North, if you read "The Washington Post"

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1 this morning on the front of the "Metro" section  
2 had a very eloquent article on the lack of  
3 availability of facilities for mental retardation  
4 victims who have to be moved 200 or 300 miles from  
5 home. We face the same gap in TRICARE in this  
6 region because without these three intermediate  
7 levels of care, we have the availability of the  
8 acute inpatient services for our patients at a  
9 very high pay rate, and we have the availability  
10 of outpatient services for our patients. The  
11 problems is, we see every day that the data proves  
12 that we have patients who are staying overlong in  
13 inpatient settings because there is no alternative  
14 level of care to send them to.

15 QUESTION: I am just a little confused  
16 because my understanding when the last speaker  
17 finished was that these partial hospitalization  
18 programs are substantially limited in part because  
19 of statute, and what you are saying sounds like it  
20 is totally supply.

21 MS. KRYSA: The IOPs are limited by

22 Washington DC 20061219 TF meeting transcripts FINAL.txt  
statute. They are not available at all. The

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1 partial hospitalization programs for half-day and  
2 full-day are actually available, they are just  
3 limited in numbers in the region that we can get  
4 to be participating TRICARE providers.

5 QUESTION: Thank you very much.

6 QUESTION: Are they limited in numbers  
7 because there are just fewer of them, or they are  
8 they limited in numbers because current programs  
9 will not accept your funding level?

10 MS. KRYSA: Both answers are correct.  
11 We have limitations in this North region having  
12 New York City, Virginia, North Carolina areas.  
13 There are many more of these programs available in  
14 the South because the labor cost is less, the  
15 facility cost is less, the charges are less, and  
16 the daily costs more approximates what TRICARE  
17 pays, what TRICARE reimburses. We have trouble  
18 getting the partial hospitalization programs in  
19 for two different reasons. One is because there  
20 are just not that many available in the region.  
21 The second is because they are very well utilized  
22 by other beneficiaries in the region who are not

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1 TRICARE beneficiaries, they are using other health  
2 insurance to pay for their care, and also just  
3 because of geographic availability of what there  
4 is.

5 The problem we have though is if you can  
6 only have an inpatient level of care and an  
7 outpatient level of care, we have a lot of people  
8 who fall through the cracks. We have done some  
9 studies to look at what the behavioral health  
10 utilization is. We have patients who are released  
11 from inpatient settings and we find that they do  
12 not follow-up in the 7 to 30 day timeframe that  
13 they need to that they should follow-up in after  
14 they have had a discharge because they do not have  
15 availability of places to go for that care.

16 It also impacts not only the family  
17 members. As Dr. Wagoner showed you, 66 percent of  
18 the people using the benefit in our region in 2005  
19 were active-duty family members, whether they --

20 Or over 18 years of age. That was 66  
21 percent of the population. It not only impacts  
22 that population who is seeking the care and who

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1 needs the care, but it certainly impacts the

2 service member who is worried about the care that  
3 their family member is getting especially when  
4 they have to be ready for deployment and leaving  
5 the area.  
6 DR. MCCORMICK: Let me ask one other  
7 question on the continuum of care. It is my  
8 understanding from a couple of site visits in your  
9 region that for substance abuse, and I am talking  
10 about substance now for an adolescent, that in  
11 fact to get regular outpatient care, that  
12 outpatient care is only covered if it is provided  
13 by an outpatient worker who is part of an approved  
14 partial hospitalization or residential facility.  
15 Is that correct?

16 MS. KRYSA: I do not know the answer to  
17 that question, but I have Marie Mentor who is our  
18 mental-health management consultant here in the  
19 audience, and I think she has that answer.

20 COL DAVIES: Could you step to the  
21 microphone since we are recording? I appreciate  
22 that, ma'am.

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1 MS. MENTOR: Outpatient for substance  
2 abuse is not covered. You have to go what is  
3 called a SUDRUF, that is substance use disorder  
4 rehabilitation facility, and that is the only way  
5 you can get it, and they are not available for us.

6 DR. MCCORMICK: I am just clarifying  
7 here. What that really means is that if there is  
8 a teenager out there who just needs regular  
9 outpatient, going back to our slide where you had  
10 outpatient and inpatient, in fact, as I understand  
11 it, it can be fudged if there is a partial  
12 hospitalization program nearby, those outpatient  
13 workers can somehow get it in, but for most  
14 people, there really is not outpatient care  
15 either.

16 MS. MENTOR: For example, sir, just  
17 recently we sent an adolescent to an outpatient  
18 program all the way to Florida right here from  
19 Virginia.

20 DR. MCCORMICK: Thank you. That  
21 clarifies.

22 DR. MACDERMID: May I ask a question

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1 also about the partial hospitalization programs  
2 with regard to active-duty members? Is it your  
3 experience that military MTFs are pretty much able  
4 to handle all of that demand and you are not  
5 getting overflow for active-duty members, or are  
6 you?

7 MS. KRYSA: I think they are handle most  
8 of the demand, but there is also demand for  
9 active-duty service members to get sent out into

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10 the neighborhoods and into the communities. The  
11 difference is in the certification requirements  
12 for partial hospitalization programs for active  
13 duty. If someone signs up to be a TRICARE  
14 provider and accepts assignment of payment, the  
15 active-duty service persons can be sent to those  
16 facilities. Active-duty family members and other  
17 family members cannot be because those facilities  
18 are not certified with that higher level of  
19 certification that is required under the National  
20 Quality Monitoring Contractor MAXIMUS. There is a  
21 different level of standard that applies for the  
22 facilities.

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1 DR. MACDERMID: That seems puzzling to  
2 me. Is that me or is it really puzzling?  
3 MS. KRYSA: It is very puzzling. It is  
4 puzzling to all of us.  
5 CAPT KLAM: Since sometimes there are  
6 available facilities but because they will not  
7 accept TRICARE's reimbursement rates, who sets  
8 those rates? Is it by statute? Is it by the  
9 contract? Who sets those rates?  
10 MS. KRYSA: The CMAC rates are set by  
11 statute. They are across the country.  
12 DR. MCCURDY: Let me say a word to our  
13 task force. As the senior member of this task

14 force, it has been within memory of some of the  
15 people on this task force when standard commercial  
16 insurance companies did not pay for outpatient  
17 care, only hospital coverage, and this is not  
18 paleohistory, by the way. This has been within  
19 the last 30 years.

20 (Laughter)

21 DR. MCCURDY: So I think the markets  
22 tend to lag behind, one, current thought as far as

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1 treatment. Then secondly, dare I say it, those of  
2 us in the mental-health provider field have not  
3 been always trusted to be true to the billing. So  
4 it was thought that the reimbursement systems were  
5 safer if the patient were in the hospital. I can  
6 remember vividly admitting patients to the  
7 hospital because it was the only way they could  
8 afford care when it was totally unnecessary.  
9 There is progress being made, so there is hope.

10 MS. KRYSA: Thank you, sir. What we are  
11 looking at is the need for increased intensive  
12 outpatient programs and expanded partial  
13 hospitalization programs. Both of those  
14 categories of care would provide greater access  
15 for beneficiaries. What we find is some patients  
16 not only stay overlong in the inpatient setting,  
17 but they also stay overlong in an outpatient

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18 setting, getting a visit a week and struggling for

19 the other 6-1/2 days until they get to their next  
20 visit and not being able to cope in the setting  
21 that they are placed.

22 It will offer earlier intervention and

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1 treatment for our beneficiaries. It would  
2 probably be a much better value for our  
3 beneficiaries than paying the much higher cost of  
4 inpatient care that is not really necessary. And  
5 it would give TRICARE the ability to meet the best  
6 practices of industry standards. The other thing  
7 that we are all looking for across the military  
8 health care system is to have consistency across  
9 the health care system, and right now there is not  
10 consistency between what is available in the  
11 network and what is available in the direct-care  
12 system.

13 We are looking at our current challenges  
14 of not having enough partial hospitalization and  
15 not having the intensive outpatient at all. We  
16 are looking at the certification requirements.  
17 JACHO has requirements, CSM has requirements, we  
18 have that extra layer of requirements since the  
19 1993 GAO report that looked at military health  
20 care and was concerned for the quality of the care  
21 and put in a caveat to have peer review both of

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22 direct care as well as the network care. We also

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1 are looking at the reimbursement. As has been  
2 said several time in the last half hour, it is  
3 lower than what is being paid by other health  
4 insurance in the industry.  
5 We have some current initiatives in the  
6 North region to try to alleviate some of the lack  
7 of care that is available. Water Reed has a  
8 virtual psychiatry program or telepsychiatry  
9 program available. They have two adult and three  
10 child psychiatrists who provide services through a  
11 virtual network to beneficiaries at a large number  
12 of military health care facilities. Portsmouth  
13 was able to hire six licensed clinical social  
14 workers to help increase their ability to take  
15 care of adolescents and children, and also one  
16 additional psychiatrist. Pax River was able to  
17 hire an additional social worker to do child and  
18 adolescent and try to recapture some of that  
19 counseling that was being sent out to the network  
20 or to nonnetwork providers at a higher cost.  
21 There were also a couple of initiatives  
22 that HealthNet has in place, one with the North

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1 Carolina Governor's Initiative for Guard and  
2 Reserve who return to communities, and also  
3 another one for visiting providers to military  
4 bases when they know of a deployment that is going  
5 to happen or they know of a unit that is  
6 redeploying or coming back to their location, they  
7 will send teams of mental-health counselors to  
8 those locations to help with reintegration of the  
9 active duty, but more so to help with the  
10 reintegration back into the family setting and get  
11 people prepared for having somebody come back from  
12 Iraq after being gone for a year, or Afghanistan  
13 or places like that. There are some efforts are  
14 going on in the TRICARE regional offices to try to  
15 alleviate some of the problems that we are having.

16 MS. FRYAR: On the last bullet on the  
17 visiting providers, are those military life  
18 consultants?

19 MS. KRYSA: I believe that is the  
20 classification, yes, and they go for just a TDY  
21 period of time to help.

22 COL ORMAN: Ma'am, what strikes me about

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1 all this, and I know you do not control it so I am

2 interested in your thoughts or recommendations,  
3 the Walter Reed initiative for instance, it  
4 appears to me what we are trying to do with that  
5 is substitute hiring hard to find, perhaps  
6 expensive local behavioral health services  
7 preferentially for using behavioral health  
8 providers in a resource-rich environment and using  
9 electrons to move the services downstream. Does  
10 that make sense to you?

11 MS. KRYSA: I do not know that it is the  
12 best solution, but I know that it is a solution  
13 that does have some merit because it does get some  
14 provider contact to those people. And they are  
15 not just out there walking into a room with a  
16 computer screen in front of them.

17 COL ORMAN: I know how it works.

18 MS. KRYSA: They do have a social worker  
19 in place to help them with their appointment as  
20 well. I do not think it is the best alternative.  
21 It would be great if we could hire psychiatrists  
22 and send them to all those military bases or those

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1 communities to work.

2 COL ORMAN: And I think the movement of  
3 providers is a function of the incentives. Again,  
4 it strikes me we are spending lots of effort, lots  
5 of resources and fairly high-priced providers and

6 we are moving them electronically, and I would  
7 have to be convinced that that is cheaper than  
8 just upping the salaries for providers to go to  
9 those areas where it made sense.

10 MS. KRYSA: As we have talked, we need a  
11 continuum of care that allows us to have all these  
12 levels of available to our TRICARE beneficiaries.  
13 We need them to be able to progress from  
14 outpatient to inpatient if it is necessary and  
15 appropriate. We also need them to be able to go  
16 the other way in the scenario that Dr. Wagoner  
17 described of not being able to go from an  
18 inpatient setting, but to go to outpatient without  
19 intermediate levels of care. We need to try to  
20 change that structure and make things more  
21 available.

22 TRO North. You said you were all the

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1 speakers for recommendations, we have our  
2 recommendations for you, and you have actually  
3 already spoken to them a little bit. We need to  
4 expand the TRICARE mental-health benefit to  
5 include those outpatient programs. We need to  
6 expand it to include more of the partial  
7 hospitalization programs, and that may be a change  
8 in the benefit or the amount that is paid for the  
9 benefit. Those are lower-cost alternatives and

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10 probably more appropriate to the need of our  
11 TRICARE beneficiaries in this region.  
12 We also need to look at the NQMC  
13 certification requirements. They were put into  
14 place for the safety of our patients in these  
15 facilities. We understand that and recognize it.  
16 But also they were put into place about 13 years  
17 ago at a time when the joint commission standards  
18 for looking at facilities only had a comprehensive  
19 hospital manual and behavioral health was surveyed  
20 under a very short group of requirements in that  
21 manual. There are now behavioral health standards  
22 that are placed out by JACHO and that hospitals

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1 are surveyed for and that they work very  
2 diligently to maintain. There are also CMS  
3 standards that they work very diligently to  
4 maintain. What we need to do is look at what the  
5 MAXIMUS standards are and make sure they are still  
6 appropriate to what we need in our facilities.  
7 COL ORMAN: Is it a fair statement that  
8 our concerns now lie primarily at the  
9 congressional level as opposed to some of these  
10 lower levels in terms of what needs to be changed?  
11 MS. KRYSA: As far as the benefit and  
12 the reimbursement, yes, those are the main things  
13 that we need to be looking at.

14 COL PEREIRA: This is going to be an  
15 awkwardly phased question because I am not  
16 politically very sophisticated at all. What  
17 changes would we need to make to allow us to be  
18 more flexible in programming to keep up with the  
19 industry instead of having the situation that we  
20 currently have where it takes 3 years to get  
21 changes made that we would implement? Is that a  
22 clear question?

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1 MS. KRYSA: It is a clear question. I  
2 am sure that the answer is not as clear.

3 DR. WAGONER: I would just like to say  
4 amen. It is a hard question. As I am listening  
5 to the presentations that you have sat through  
6 yesterday and today, also I was struck with the  
7 time that you are spending on this. When I had  
8 the opportunity of coming I just wanted to say  
9 thank you very much to this group for wrestling  
10 with this. It is a lot of time and energy.

11 My suggestion actually is to think big  
12 and ask yourself is what I am recommending or  
13 proposing big enough, because I think we have very  
14 exquisite solutions to only parts of the system.  
15 As I listened to many of the programs and  
16 recommendations, they are wonderful programs, but  
17 in my opinion they are not big enough. Having

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18 something that you can recommend that is large  
19 enough and flexible enough is the key. How to do  
20 that is not an easy task, and I certainly do not  
21 think I can answer that in 10 or 15 seconds, but  
22 that is the task in my opinion, something that is

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1 big enough and flexible enough.  
2 MS. KRYSA: And to try to further answer  
3 your question, ma'am, there are other ways now in  
4 statute a little bit more rapidly. Looking at the  
5 National Defense Authorization Act of 2007 that  
6 has just come out, but 2008 will be coming as  
7 well, they are already working on that. And if  
8 some of these things like the IOP as a benefit are  
9 put forth there, they may get into the statute  
10 sooner than 3 years.

11 But we just need a task force such as  
12 yourselves to recognize the need to change the  
13 benefit structure a little bit and we need to  
14 include those type of level of care, and there is  
15 some discussion across the whole military health  
16 care system as to how big a problem mental health  
17 is. One of the problems we have is for years we  
18 had lots of data that said how many people went  
19 outside the network to get their mental-health  
20 care. What has happened over time is the  
21 providers in the military system as well as the

22 Washington DC 20061219 TF meeting transcripts FINAL.txt  
network providers in the community are well aware

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1 that there is no intensive outpatient therapy  
2 available as a benefit so they have quit asking  
3 for it. Family members who are using the brunt of  
4 this amount of health care are getting that care  
5 through mom's OHI or other health insurance or  
6 paying out of pocket for the expenses. We at  
7 TRICARE really do not have the ability to track  
8 what is happening and how many of those patients  
9 there are. We can see what the numbers are of  
10 kids who are being sent out for mental-health  
11 care, it is an increasing number, and I fear that  
12 it is going to continue to increase with all of  
13 the deployments we have and parents gone.

14 The situation especially in the Northern  
15 Virginia area when we read the newspaper every day  
16 and there have been 285 Iraq funerals at Arlington  
17 Cemetery. They are on the front page of the paper  
18 almost every day and that does have an impact on  
19 the children here.

20 DR. MCCORMICK: I was going to ask a  
21 question we have not talked about. From our  
22 perspective, we try to look at access as meaning

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1       that the wife of an E-2, relatively  
2       unsophisticated, can get herself or her kids to  
3       care. One of the things we hear is that there are  
4       Websites with providers listed on them, and we  
5       hear this repeatedly that a family member calls  
6       maybe 10, 12 or 15 more providers before they find  
7       one who will take new TRICARE people, and this is  
8       the TRICARE Websites, which of course discourages  
9       somebody and maybe discourages them enough if they  
10      are not sophisticated to stop altogether.

11               Who is responsible in the region that  
12      you cover for assuring that the Website list of  
13      providers are actually taking cases in some  
14      current way? And if it is you who are  
15      responsible, what is your procedure for doing that  
16      kind of washing the list to make sure that it is  
17      current and navigable by an unsophisticated  
18      person?

19               MS. KRYSA: The managed-care support  
20      contractor is responsible for the list of the  
21      providers that they have contracted with to be  
22      within the TRICARE network and those are the ones

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1       that appear on the Websites. The problem we have

2 is, as was mentioned earlier, there is a lot of  
3 patriotic duty out there and a lot of providers  
4 are willing to take TRICARE, but not to a large  
5 extent because the payment is less. The problem  
6 is, as you said, we get people who call several,  
7 maybe even a dozen providers on the list and find  
8 nobody who is taking new TRICARE beneficiaries at  
9 that time.

10 We try to report that information to  
11 HealthNet and sure that they are aware that those  
12 providers are not taking new beneficiaries, but we  
13 do not want to take them off the list because they  
14 may next week be taking them. What happens is  
15 there is a group responsible for network adequacy  
16 who actually has outgoing calls to providers on a  
17 regular basis to see what they are taking as far  
18 as TRICARE beneficiaries to try to keep that type  
19 of information updated, but they use that  
20 information more than just keeping the list  
21 updated to see where their recruitment efforts  
22 need to be to get more providers into TRICARE.

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1 Unfortunately, in some of our  
2 communities, and we have Fort Campbell that was  
3 the 101st, and we have Fort Bragg that has the  
4 82nd, we are maxed out on the available providers  
5 in the communities. They have seen that they can

6 take TRICARE beneficiaries, and they cannot take a  
7 lot. In other areas, the providers just are not  
8 willing to sign up to take TRICARE assignment, and  
9 that is a problem.

10 COL ORMAN: It would appear to me, those  
11 E-2 and E-3 beneficiaries need somebody to help  
12 them negotiate finding a provider to avoid the  
13 discouragement if you are depressed or distressed  
14 of making these multiple phone calls. Is the  
15 problem in the contract itself that that is not a  
16 functional requirement or a service that is built  
17 into the contract?

18 MS. KRYSA: They are helped. They do  
19 have referral management centers who if they are  
20 sent out to network care will help them try to  
21 locate an available provider who can see them.  
22 The problem we have though is, yes, they do get

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1 sent sometimes or referred to people who just do  
2 not have the availability. The problem in the  
3 contract is that we do not have control of  
4 appointing in the contracts. We may give or  
5 HealthNet may give a referral to a beneficiary and  
6 send them out there to find the care and HealthNet  
7 will never know if they actually got appointed for  
8 care or not because the appointing process is  
9 given back to the individual patient. As we have

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just said, with a lot of our beneficiaries who are

seeking behavioral health, that is not the best  
option and that may be the contractual problem  
that needs to be corrected or needs to be looked  
at.

MS. POWER: In terms of trying to make  
the TRICARE program more effective is that we are  
stuck in a mental model of how the TRICARE program  
is defined by code and regulation, et cetera. As  
I look at our recommendations, would your  
recommendations be consistent with the notion that  
we clearly want to focus on recovery and  
resilience for members of the military and for

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their families? And could we expand your  
recommendations to also include a higher use and a  
higher application of evidence-based practices,  
and rather than trying to fit people to program or  
program to people, but that we could encourage the  
use of evidence-based practices like assertive  
community treatment, like family psychoeducation,  
like medication management? Would that be  
inconsistent with some of the things that you are  
talking about?

MS. KRYSA: It absolutely would. We  
actually have several members in the TRO office,  
Marie Mentor who you met a few moments ago as well

14 as Colonel John Morris, who have been very active  
15 in looking at mental health and behavioral health  
16 and what is available and what is not. There is  
17 another work group, and I hear you will hear from  
18 Mike O'Bar later on this morning who is going to  
19 talk probably about what is going on in that work  
20 group as well, that was put together to start  
21 looking at these issues. It sometimes seems that  
22 we do not on each side of the street know what is

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1 happening across the region because we knew that  
2 that work was in place and then we heard about  
3 this wonderful task force as well.

4 There is awareness now that mental  
5 health and behavioral health is a big concern for  
6 our TRICARE beneficiary population and I applaud  
7 your efforts as well as the work group's efforts  
8 to try to help us find a way out of that.

9 DR. MACDERMID: I have a question about  
10 the expansion of the intermediate treatment  
11 options. Are you aware of anybody ever having  
12 tried to run any numbers about the cost impact of  
13 expanding those intermediate options and,  
14 therefore, reducing reliance on the very expensive  
15 inpatient treatment?

16 MS. KRYSA: We actually run those number  
17 ourselves in the TRICARE regional office to see

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18 what our utilization is. When we get those long  
19 lengths of stay from inpatient care, and the NQMC  
20 and MAXIMUM actually gives us those kind of data  
21 as well, we look back and say if this person could  
22 have been sent to a different level of care, what

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1 would the cost difference have been if this level  
2 of care had been available.  
3 DR. MACDERMID: I think it would be  
4 helpful for us to see some of those numbers if you  
5 could provide them.  
6 MS. KRYSA: I think we could certainly  
7 get that for you.  
8 COL ORMAN: It strikes me that the  
9 reason we are having this task force and the  
10 reason that we have not changed the statute since  
11 1993 is there is really no advocacy and expertise  
12 being applied across DOD services to making sure  
13 that the mental-health benefit keeps up with the  
14 times, if you will. And further that in the event  
15 of things like GWOT that somebody has somebody has  
16 got their eye on the ball about what is probably  
17 going to be coming downstream. Is that something  
18 you worry about, that somehow there really is not  
19 any expertise? Do not get me wrong. There are  
20 lots of clinical experts, but it is like people  
21 feeling the elephant, there is nobody who is

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22 responsible and has the credibility and the

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1 platform to say we are way behind on what we need  
2 to do with statutes so that we can do things like  
3 IOPs, et cetera. Does that make sense to you?

4 DR. WAGONER: My comment is amen. Can  
5 you repeat that whole thing three times?

6 (Laughter)

7 MS. KRYSA: There are people who are  
8 overseeing this who are looking at all the  
9 problems, but you are right, I think there is not  
10 a real uniform approach to what we need to look at  
11 and what we need to do. There are these work  
12 groups, your task force as well as the other work  
13 groups, starting to look at these things and  
14 starting to solidify some of the comments. We  
15 hear things like all of your evidence is  
16 anecdotal, we do not really know that this is  
17 true. We have looked at numbers, but as I  
18 mentioned a few moments ago, people stop asking  
19 for something that is not a benefit so it is very  
20 hard to track how much utilization it would get.

21 COL ORMAN: There is no inside advocacy  
22 is my point. There is nobody saying I represent

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1 behavioral health for now and in the future and we  
2 are going to keep up with this stuff.  
3 MS. KRYSA: We would like to promote  
4 expansion of the health networks very hard to look  
5 at where we need more providers, to go out and  
6 they recruit providers. In those white space  
7 areas that someone was addressing a little while  
8 ago for the standard beneficiary or the Reserve  
9 Select who live out in Lake Gaston, North  
10 Carolina, or some of those places, we have a work  
11 group in our own offices looking at what the  
12 availability of providers are for PCMs as well as  
13 specialty practices in those areas as well looking  
14 at where there is a concentration of at least 300  
15 folks who would be TRICARE beneficiaries, where  
16 there are concentrations of 500 or 1,000, trying  
17 to see where else the network might need to expand  
18 or where else we need to do a better job of  
19 broadcasting the need for beneficiaries providers,  
20 and I think that that is one of the things we need  
21 to work on as well, getting providers aware of  
22 TRICARE. You will have them say I take Medicare

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1 and I take TRICARE, but they have never signed on

2 the dotted line that said they accept assignment,  
3 they never become a network provider. And if they  
4 are not a network provider, HealthNet cannot be  
5 sending people to them. You can find somebody who  
6 take assignment on your own, but actually being  
7 sent to them and being referred to them, we have  
8 to credential them and make sure they are  
9 appropriate to be in the networks.

10 DR. MACDERMID: Those would be other  
11 numbers that would be very helpful for us to have  
12 because it is very consistent with what we have  
13 been hearing on our site visits, but we have the  
14 same issue where we want to make sure that we have  
15 systematic empirical data in addition to anecdotal  
16 data before we draw any conclusions. So if there  
17 are summary tables or reports of these analyses of  
18 where is coverage good and where is it bad and  
19 what are the needs, we would be very grateful to  
20 receive that information.

21 MS. KRYSA: We can get that information  
22 for you.

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1 This represents my fourth generation of  
2 TRICARE beneficiaries in my family. I have a  
3 vested interest in this task force doing the best  
4 they can for the mental-health benefit. Thank  
5 you.

6  
7 DR. MCCORMICK: Let me make one comment  
8 if I could. I would be remiss if I did not. In  
9 traveling around in your network, I have heard  
10 some very positive things, and I think those goes  
11 to both of you, from providers about the  
12 reasonableness of the process for reviewing care  
13 plans, the reasonableness for negotiating what the  
14 patient needs. We understand that there are  
15 restrictions on the fence you can work within, but  
16 I do want to pass along those compliments about  
17 how you work for the benefit of patients within  
18 that fence.

19 DR. MACDERMID: Now we have a break for  
20 minutes, until 9:30. Why don't you take 10?

21 (Recess)

22 DR. MACDERMID: I would like to welcome

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1 Ms. Martha Lupo, Ms. Martha Jacques, Dr. Gary  
2 Proctor, and Ms. Julie Ice who are here to speak  
3 with us about Humana and the TRICARE Southern  
4 Region. I would also like to make an announcement  
5 that there are members of the media present and we  
6 welcome their presence, but we want to make clear  
7 to presenters and to audience members that the  
8 question periods are limited to members of the  
9 task force and that if members of the media have

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10 questions that they would like to ask of speakers,

11 please feel free to do that in the hallway after  
12 the sessions are done. Welcome to our speakers.

13 MS. LUP0: Thank you much and good  
14 morning. The purpose of our briefing here today  
15 of course is just like all of our brothers and  
16 sisters who have reported to you from the other  
17 two regions, to present an overview of the  
18 behavioral health benefit and how it is delivered  
19 in the South Region which is our task. And to  
20 touch on some of the task force areas of focus for  
21 the -- '07 and specifically Section 723.

22 This is an outline of what we will be

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1 talking about. I am going to try to steer away  
2 from some of the things that have been emphasized  
3 in the other two regions. We deliver the same  
4 benefit under the contracts in all three regions.  
5 Some nuances are a little bit different, but  
6 basically we are the same, so we will try to  
7 emphasize some of the things that perhaps they did  
8 not have time to do and to make it interesting for  
9 you.

10 The first slide shows you a regional  
11 map. In case nobody showed you the geography,  
12 this is what it looks like. We had a question  
13 here, how come North Carolina is not part of the

14 South. All I can say is some Yankee drew the  
15 lines.

16 (Laughter)

17 MS. LUP0: We have 10 states in the  
18 South that we oversee the health care there. We  
19 have about 2.9 million beneficiaries. Because our  
20 focus is active-duty and active-duty dependents, I  
21 gave you the numbers there. Over 80 percent of  
22 our active-duty beneficiaries are enrolled in

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1 Prime which is an important point because that  
2 lowers certain cost barriers that those who are  
3 not involved in Prime do experience.

4 The two primary sources of behavioral  
5 health care in the south. First, the Direct Care  
6 System. This system is under the command and  
7 control of the service surgeons general, and they  
8 deliver mental-health there. It is outside my  
9 scope to talk about that and I am sure you will be  
10 talking with them about what they liver there.  
11 But the most important point here is that a lot of  
12 the active-duty care is delivered within that  
13 system.

14 The second major deliverer of behavioral  
15 health care out there are the managed care support  
16 contractors particularly through their  
17 subcontractor in our region which is Value

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18 Options, and Humana is the prime contractor, of  
19 course.

20 The purpose of the managed care support  
21 contract is that it is a wrap-around contract as  
22 we call it. What they do is particularly in MIF

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1 areas and around BRAC areas, they wrap around or  
2 provide the full benefit. In other words, what  
3 cannot be provided at the MIF they either provide  
4 more of it or fill in the holes there, so it is a  
5 wrap-around type contract. It is to supplement  
6 the resources available from the MIF and enable  
7 the delivery of behavioral health benefits. Our  
8 focus is really beyond the NCSC delivery portion  
9 of the behavioral health benefit.

10 You have seen this slide before. This  
11 is the basis of our benefit. Some of our benefit  
12 is defined in statute or U.S. Code which is  
13 translated then again as we have heard before into  
14 federal regulation which is 32 C.F.R. A further  
15 refinement of those areas you will find in our  
16 policy manuals, and they are available on the Web.  
17 The TRICARE Policy Manual and the TRICARE  
18 Operations Manual will detail how a lot of we are  
19 supposed to be delivering all of our benefit, so  
20 that might be something for the analysts to take a  
21 look at as they peel apart the issues. The U.S.

22 Washington DC 20061219 TF meeting transcripts FINAL.txt  
Code, the C.F.R. and all of the manuals are

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1 incorporated by reference as part of the TRICARE  
2 contract, so the managed care support contractors  
3 are tasked and required to comply with all of the  
4 requirements therein.

5 Taking a look at utilization, sometimes  
6 that is an index of access, and this is what you  
7 see for FY 05. We use FY 05 because it is a  
8 complete year. Providers have up to 1 year to  
9 file claims, and so to have a mature and  
10 relatively complete year, FY 05 is it, and that  
11 pertains to claims for active-duty and active-duty  
12 family members. The active-duty claim is about \$5  
13 million, and about 3.1 percent of in purchase care  
14 for active duty, and that reflects I think that a  
15 lot of the care is provided within the MIFs for  
16 active-duty members. For active-duty members,  
17 about \$29 million was paid which is about 8.3  
18 percent of dollars paid for all care for active-  
19 duty dependents to give you a focus on it. We can  
20 provide more data on that. We would be glad to do  
21 that separately. I do not want to get too deep  
22 into statistics right now, but we will be happy to

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1 provide the task force with any data.

2 DR. MACDERMID: We love data, and it is  
3 Christmas time. Please send us data.

4 MS. LUP0: We will put all of those  
5 together and send you the spreadsheets and the  
6 information papers to interpret those spreadsheets  
7 if that is agreeable.

8 Moving on to the next side, I would like  
9 to present Dr. Gary Proctor who will be talking  
10 about the behavioral health providers that we have  
11 in the South network.

12 DR. PROCTOR: Thank you, Martha. As Dr.  
13 Wagoner mentioned, if you do have any questions  
14 during the presentation, please feel free to  
15 interrupt at any time.

16 In the South region, Humana Military  
17 with Value Options as a subcontractor has a little  
18 over 9,200 network providers in the South region.  
19 These are individual providers. This includes  
20 psychiatrists, psychologists, doctoral-level  
21 clinical psychologists, masters-level providers  
22 which include clinical social workers, nurse

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1 practitioners, marriage and family therapists,

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2 pastoral counselors, and mental-health counselors.

3 The breakdown of the numbers in that 9,270, the  
4 psychiatrists are approximately 1,600 or so, we  
5 have over 2,000 clinical psychologists, and the  
6 remainder are the masters-level providers.

7 In addition to individual providers, we  
8 have 255 facilities currently with a number of  
9 programs, and in a few slides we will discuss that  
10 a little more in-depth. In addition to the  
11 network, there are a large number of nonnetwork  
12 providers. In a recent claims look that we had  
13 run, there were over 7,000 claims from different  
14 nonnetwork providers that were received, but these  
15 are usually onesies and twosies. The actual  
16 number of nonnetwork care in the South is limited.

17 One of the issues that we took out of  
18 the NDAA that we wanted to address for the task  
19 force was services and languages other than  
20 English that were available in the South region,  
21 and of our 9,270 providers, 1,404 of them have  
22 indicated that they do have a language proficiency

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1 in a language other than English. Spanish is by  
2 far the highest which is important in the South  
3 because we do cover South Florida and we cover the  
4 Texas region also, and 33 languages are  
5 represented.

6 For the network, which would be true in  
7 the West region and the North region, too, we do a  
8 fairly extensive background check and  
9 credentialing process and recredentialing process  
10 for our providers that includes a criminal history  
11 background check, national practitioner databank,  
12 and Medicare check. We look into their  
13 educational and training requirements, also their  
14 licensure, any malpractice issues in the past, and  
15 we also ensure that they have current adequate  
16 malpractice insurance. Also we will look at any  
17 other kind of required certifications when there  
18 is not a license afforded by the state. This  
19 would be such as an applied behavioral analyst  
20 position type of provider that provides ABA  
21 therapy. They have national certifications, but  
22 many states do not recognize them as an individual

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1 provider.  
2 DR. MCCORMICK: May I ask a question?  
3 DR. PROCTOR: Yes, sir.  
4 DR. MCCORMICK: As we highlighted  
5 before, there really is not currently a benefit  
6 for straight outpatient substance abuse for  
7 teenagers, for example. Much of the care that you  
8 do cover is actually provided in residential  
9 facilities by certified drug and alcohol

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10 counselors. If there were to be a benefit added

11 for straight outpatient substance abuse, my  
12 question is, would you then be able to cover CDACs  
13 as providers? I guess the real question is, who  
14 determines who can be a provider? Is that statute  
15 or is that something that is left up to you as  
16 Value Options?

17 DR. PROCTOR: We are not able to  
18 determine provider types. That is determined by  
19 policy, and I believe it is also in regulation.  
20 Individual certified outpatient addiction  
21 counselors are not covered. You are correct that  
22 individual outpatient substance treatment even

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1 with an ACM addictionologist would not be covered  
2 under the current benefit plan.

3 In addition to the individual providers  
4 that we have in the South, we have 255 total  
5 facilities. This would include a number of  
6 different facility types and different program  
7 types. When you break down the different programs  
8 that are available in the South, we have 216  
9 inpatient psychiatric programs and 128 inpatient  
10 detoxification programs. One point I would like  
11 to point out also is detoxification on an  
12 outpatient basis so to speak is not a covered  
13 benefit currently. We have 73 inpatient

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rehabilitation programs for chemical dependency.

There are 10 partial hospital programs in the  
TRICARE program and eight of these are network.  
There are 88 substance abuse partial programs, and  
there are 15 residential treatment programs and  
all 15 are within the network.

MS. LUP0: With this slide I wanted to  
show you that when we talk about barriers to care  
and cost, I know that certainly on the commercial

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side, the cost shares and deductibles and cost of  
care is much higher than what we are providing  
under our benefit here. I just wanted to show you  
and flash up there that this is also available in  
the TRICARE web and what the co-payments are for  
active-duty family members. For the various  
services you see down on the left-hand column, if  
they are enrolled in Prime, and remember 80  
percent of them are, there is no co-payment for  
those services. Of course, if they elect not to  
enroll in Prime, these are the co-payments for  
Extra and Standard which can run into considerable  
out-of-pocket costs. This is why we emphasize so  
much Prime and the advantages that it gives to  
active-duty family members in terms of cost of  
care.

Some of the access to care, and that was

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18 one aspect of access to care and let's talk a  
19 little bit more about that since folks really have  
20 not at least in the last presentation talked too  
21 much about it specifically. Some of the things we  
22 have in place for active-duty family members, they

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1 can self-refer for the first eight mental-health  
2 visits without a referral and authorization. That  
3 is something that you do not really see too much  
4 on the commercial side, and it is there by design.  
5 When this benefit was first designed circa 1993,  
6 that was designed specifically for that purpose,  
7 to decrease a person's embarrassment or emotional  
8 barrier that they might have to go through, their  
9 PCM to go see a mental-health counselor. This was  
10 to help people feel free to contact those  
11 providers without anybody's particular permission.

12 DR. MACDERMID: In what unit of time are  
13 those first eight? Is that lifetime, per year,  
14 per problem?

15 MS. LUP0: It is for fiscal year.  
16 Secondly, the cost share versus inpatient and  
17 outpatient, we already talked about that for  
18 active duty. Of course, under the supplemental  
19 care program there is no co-payment or cost share  
20 for purchased care. We just detailed the cost  
21 shares and the deductibles and so forth depending

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on whether they use Prime or other.

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1 If medications are required to treat  
2 their condition, there is no cost at the MIF for  
3 those medications if they can get them there. If  
4 they cannot, then there is retail and they will  
5 order the capability and these are the cost shares  
6 for that. They are very low. Of course, there is  
7 no cost share for medications.

8 Assistance with finding providers who  
9 have questions, we recommend in the South that you  
10 use the Value Options 1-800 number. We have it on  
11 a number of our handouts and fliers and certainly  
12 on the Web. This gets you to somebody who can  
13 help you pretty directly with any questions or  
14 needs for access. There is also the Humana web  
15 that is available for folks to go and get  
16 information from. Or they can visit the TRICARE  
17 service centers who are located at BRAK sites and  
18 at the MIFs to get assistance if they so choose.

19 The other part of the benefit that I do  
20 not think anybody has mentioned is that if a  
21 person is referred to a provider that is greater  
22 than 100 miles, then they can be eligible for the

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1 TRICARE Prime travel benefit which will pay per  
2 diem, a medical attendant if that is necessary to  
3 transport that person for that particular episode  
4 of care. So that is out there too as far as  
5 helping to break down some of the financial  
6 barriers of getting care if it cannot be found  
7 locally.

8 DR. PROCTOR: One of the key points that  
9 seemed to be brought up in the Act was how TRICARE  
10 coordinates with community-based resources. In  
11 the South this is primarily done via individual  
12 case management. These are the more high-risk,  
13 high-cost beneficiaries. Certain community  
14 resources that may not be available under the  
15 TRICARE benefit would include community mental-  
16 health types of resources such as day treatment  
17 programs and crisis intervention units. There are  
18 group homes, halfway houses, and wrap-around  
19 services in home that are provided by various  
20 other funding sources that our case managers will  
21 assist the beneficiaries in accessing as  
22 eligibility allows.

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1 There are also Web links to various

2 community-based resources in the web. So we will  
3 use the case management program to coordinate with  
4 these community resources, and that is the process  
5 that is done in the South region.

6 MS. LUP0: Outreach in education was  
7 something I did not hear talked about too much,  
8 but I know in the South we have some good news  
9 there. First of all, we have lots of Web  
10 information out there and I turned in a notebook  
11 that I pulled down every piece of web literature  
12 about mental health and have turned it over to  
13 someone's custody, so you can take a look at that,  
14 but you can also access it on the Web. The neat  
15 part about that one when I was reviewing was that  
16 the topics were all easily readable, not at a high  
17 level of understanding, and they all were germane  
18 to what is happening today within our particular  
19 beneficiary population. Things like discussions  
20 of the stages of deployment and reunion  
21 experienced by military families. Certainly if  
22 people have concerns about that or want to get

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1 prepared for the homecoming, those materials are  
2 available and they are very good.

3 Symptoms of mental illness. This is  
4 general information out there so hopefully people  
5 will learn if they see things that do not seem

6 quite right, they can get more information about  
7 what the symptoms of mental illness are. These  
8 questions in 723 also talked about what do you do  
9 to help people identify behavioral illness or  
10 mental illness, so there is specific information  
11 out there on these topics which are of particular  
12 interest to our beneficiary population, like ADHD,  
13 autism, opposition or defiant disorder, PTSD,  
14 eating disorders, substance abuse, suicide,  
15 depression, anxiety disorders, bipolar disorder,  
16 schizophrenia, and personality disorders. All of  
17 that information is out there in fairly plain  
18 language that is accessible and can help folks  
19 with educating themselves about identifying these  
20 particular problems.

21 We also have periodic provider and  
22 beneficiary newsletters which are sent out to our

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1 beneficiaries and our providers in the network  
2 which highlight various issues of behavioral  
3 health of the day, so those are going out to our  
4 providers and beneficiaries. Value Options and  
5 Humana also sent out, and there is a handout in  
6 the notebook that I submitted, a specific handout  
7 to the Reserve component regarding the  
8 identification of symptoms post-deployment, PDTS  
9 and depression in particular, so those were mail-

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outs to the Reserve component.

11 In the South, we have found that  
12 probably our greatest challenge in TRICARE is  
13 getting the information to the beneficiary who can  
14 use it so they know their benefit and understand  
15 who to call when they need help. We have done a  
16 number of things. One of the things we did was we  
17 try to leverage the experience, knowledge, and  
18 connections of those health advisers in the Guard  
19 and Reserve units, Army, Air Force, and Marine  
20 Reserves. We have made contact with all those  
21 establishments, with all of the state Guard units,  
22 with all of the helping personnel that they have

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1 there we have linkages to them. We have quarterly  
2 meetings with them via VTC to keep them up to date  
3 on what is going on, and they have our number in  
4 return if they need anything or have any questions  
5 or concerns. We have set that up, and hopefully  
6 as people understand more about their benefit,  
7 that mental health is also part of that benefit.

8 We send postcards directly to the homes  
9 of new active-duty families regarding their  
10 benefit and who to call for questions. You would  
11 be surprised at the number of call backs we get  
12 from that, and it is a postcard that is a magnet  
13 and it has all those numbers that you stick on

14 your refrigerator, you all have it I am sure, all  
15 those special numbers on our refrigerators. We  
16 have found that this is a good way people to not  
17 lose it and perhaps refer to it. We get a lot of  
18 calls saying I didn't even know I had a health  
19 care benefit, so we are getting responses and we  
20 are getting through to the newly accessed out  
21 there. Certainly, as they learn about their  
22 TRICARE benefit in general, they will learn that

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1 they have a mental-health benefit as well.  
2 We have TRICARE Direct to You which is a  
3 computer and audio connection and we connect with  
4 the various Guard and Reserve units. We can  
5 actually broadcast instruction on various issues,  
6 any issue really, and have it interactive. What  
7 we are trying to do is push this forward to the  
8 Guard and Reserve constituency so that we can talk  
9 about the various aspects of the benefit with the  
10 beneficiaries. We could have up to 200 people in  
11 the room and run those slides and have it  
12 interactive. It is a little slow getting started,  
13 so any help that you can give with getting the  
14 word out, that is a great venue for getting the  
15 word out about mental-health benefits and how to  
16 access as well.  
17 We do three regular broadcasts out

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18 through that to the Guard and Reserve. They can  
19 sign up on the Web or we can do it ad hoc as they  
20 need it, and the three that we have in the can  
21 right now are TRP and your benefits under TRP,  
22 TRS, your benefits under that, and the benefits

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1 after deployment. Sometimes there is a lot of  
2 confusion about where your benefits are after you  
3 return from deployment, so that is one of the  
4 canned broadcasts that we have using that system.

5 That brings us to the end of our  
6 presentation, and we are subject to your  
7 questions.

8 DR. BLAZER: I will just start out with  
9 I want to ask specifically about the 1,600  
10 providers that you have in psychiatry. I know by  
11 rumor that a number of psychiatrists actually  
12 choose not to sign up with organizations like  
13 Value Options, and I am curious about do you feel  
14 like you have an adequate of psychiatrists under  
15 the Value Options, and of those psychiatrists who  
16 are under Value Options for Humana military, do  
17 you have them actually, again, putting limits that  
18 limit the likelihood of people having available  
19 psychiatric care? I am not talking so much about  
20 distribution here because I know that that is  
21 going to be issue. I am talking more about the

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22 hesitancy of psychiatrists to participate in this

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1 program due to cost restrictions.  
2 DR. PROCTOR: There are a number of  
3 issues with regard to psychiatrists in particular  
4 participating in the network, and reimbursement is  
5 certainly one of the top ones. Child  
6 psychiatrists as a subset of psychiatrists is even  
7 higher of a challenge. When you have a limited  
8 number geographically as you mentioned of  
9 psychiatrists in some of these rural areas where a  
10 number of bases are, it is not financially or  
11 business smart for them to take a high load of  
12 TRICARE beneficiaries. They do for patriotic  
13 reasons a lot of times participate, but at times  
14 there are access issues when we need to clinician  
15 where we have a clinician call their office and  
16 say this patient really needs to get in to see  
17 you. So we do very diligently try to get patients  
18 in to see, and we have 99 percent of our  
19 authorizations into the network, however, it is a  
20 struggle at times, and in particular with  
21 psychiatrists.

22 DR. MACDERMID: Can you tell us how

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1 individualized case management happens in your  
2 network?

3 DR. PROCTOR: Case management can happen  
4 by a variety of different avenues. A beneficiary  
5 can self-refer. A provider can refer a  
6 beneficiary for case management review. Our  
7 clinicians when they do perhaps concurrent review  
8 either on an inpatient or an RTC level of care can  
9 refer to case management. The MTF can refer for  
10 case management. There is a case management  
11 referral form out on the Humana military Website,  
12 so there are a number of avenues to get case  
13 management evaluation.

14 DR. MCCORMICK: Value Options is a  
15 behavioral carve-out of Humana. Is that correct?

16 DR. PROCTOR: That is correct.

17 DR. MCCORMICK: One of the issues that  
18 would be good for us to learn more about are what  
19 the incentives are. Is the carve-out paid on a  
20 per capita basis? What are the incentives for  
21 your carve-out? Are you paid on a per capita  
22 basis? Are you paid on some cost over the actual

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1 billings that you do?

2 DR. PROCTOR: You mean the contract  
3 between Value Options and HMHS?  
4 DR. MCCORMICK: Right.  
5 DR. PROCTOR: The way the current  
6 contracts are set up is administrative in nature.  
7 Julie Ice is our Humana military representative.  
8 Perhaps she would want to field that question.  
9 MS. ICE: I would have to say our  
10 contract with Value Options is proprietary and I  
11 cannot share that information.  
12 DR. MCCORMICK: So you cannot tell us  
13 whether there are incentives for Value Options to  
14 see fewer people as often is true in a capitated  
15 contract?  
16 MS. ICE: I cannot discuss our contract  
17 negotiations with Value Options.  
18 DR. MACDERMID: I am interested in the  
19 evidence about the merits of having people be able  
20 to self-refer for these right mental-health  
21 visits. Has anyone run any numbers on what that  
22 has done to the use of mental-health services? We

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1 have been trying to discuss and we have been  
2 learning about having people have to go through a  
3 primary care provider versus not and where do they  
4 get the best care. Do you have any data about  
5 that?

6 DR. PROCTOR: Data for that is somewhat  
7 difficult. The initial eight with the self-  
8 referral has been in place for a number of years,  
9 at least since the beginning of the TRICARE  
10 contracts. Self-referral is the standard in the  
11 industry. There are certain pass-throughs as what  
12 the industry would call it of a certain number of  
13 visits. The eight unmanaged from a process  
14 standpoint has been somewhat confusing for  
15 beneficiaries. If a beneficiary is seeing perhaps  
16 two providers, a psychiatrist and let's say a  
17 social worker for therapy, those eight are total  
18 per beneficiary per fiscal year and at times the  
19 providers do not know how many visits the  
20 beneficiary has accessed. Value Options actually  
21 offers all of our network providers an unmanaged  
22 eight authorization to keep those claims payments

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1 from happening, but in general the eight is  
2 somewhat confusing for beneficiaries.  
3 I do not have any data specifically to  
4 say whether that increases access or whether is  
5 beneficial or not. We did run some recent numbers  
6 in one of our MIF areas, one of our Prime service  
7 areas, that the number of referrals coming out of  
8 the MIF that actually resulted in a claim, a visit  
9 to that behavioral health provider, there was a

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10 match between the authorization and the provider,  
11 was about 50 percent. For beneficiaries who  
12 called up and self-referred, and we entered that  
13 authorization, there was match of about 80  
14 percent. From data and, again, that is very  
15 limited, it does seem to be that if the  
16 beneficiary is able to pick their own provider and  
17 is able to self-refer that they might follow-up a  
18 little bit higher than if they are referred by  
19 PCM  
20 DR. MACDERMID: Do you have any evidence  
21 or any perception of whether the sessions offered  
22 through One Source have cut into your business?

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1 DR. PROCTOR: We have not seen a  
2 decrease in outpatient utilization from One  
3 Source. There are some issues. In the transfer  
4 between One Source and continued outpatient mental  
5 health, a number of their providers are not  
6 TRICARE providers, and I do not know if other  
7 speakers have brought that issue up, but they are  
8 able to have certain provider types and providers  
9 that are not TRICARE certified, and then there is  
10 a continuity of care issue that arises.

11 COL CAMPISE: I have a question for you.  
12 If I understood correctly, you cannot tell us if  
13 there are financial incentives for not seeing more

14 clients. I am wondering if you can answer a  
15 different question that is related. In one of our  
16 base visits there was a network that had two child  
17 and adolescent psychiatrists. It turns out there  
18 was only really one and the other one had not seen  
19 anybody for a year, so they were having to wait 9  
20 months for their initial appointments. Can you  
21 tell us what you do to rectify situations like  
22 that?

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1 DR. PROCTOR: In areas that we are  
2 having difficulty finding providers, and in  
3 particular, a child psychiatrist is a good  
4 example, we will do two things. On the provider  
5 relations side we will try to recruit every  
6 appropriate provider that is in the area and we  
7 will reimburse them up to the CHAMPUS allowable  
8 rate to come into the network. Especially with  
9 psychiatrists you have to go to CMAC many times.  
10 So we will try to get as many providers, and then  
11 we may have to reach out 40 or 50 miles to get as  
12 many providers that are available and that will  
13 participate.

14 On the utilization management referral  
15 side, we have done some say perhaps innovative  
16 things depending on the case. If there are  
17 pediatric groups or family practitioner groups

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18 that have providers who are either, A, specially  
19 trained in behavioral health issues, sometimes you  
20 will have a family practitioner who has done a  
21 psychiatric residency and these are few and far  
22 between, but we will work with other provider

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1 types who have specialized behavioral health  
2 services available if it is just a referral outlet  
3 for ADHD medication. Sometimes we have to bring  
4 them into case management, sometimes the Prime  
5 travel benefit comes into effect, so there are a  
6 number of things that we try to look at in those  
7 situations.

8 DR. MACDERMID: I will ask you the same  
9 question that we have asked many of our speakers,  
10 if you could suggest to us things that we should  
11 recommend what would you suggest?

12 DR. PROCTOR: You mean like a Christmas  
13 list?

14 DR. MACDERMID: Sure.

15 DR. PROCTOR: I could speak for Martha I  
16 think, too, that we mostly agree with the majority  
17 of what the North indicated with regard to IOPs  
18 and different levels of care. The flexibility in  
19 the benefit is a restriction. The different types  
20 of providers, the different types of levels of  
21 care are definitely problematic.

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1 or lack of?  
2 DR. PROCTOR: Lack of flexibility. One  
3 level of care, one provider type that was not  
4 brought up here at least today that I did want to  
5 mention are free-standing eating disorder sorts of  
6 programs. Eating disorders, in particular  
7 anorexia, are one of the highest morbidity and  
8 mortality mental-health disorders that are out  
9 there and free-standing eating disorder programs  
10 that are not hospital based are not a TRICARE  
11 benefit. This is actually policy based. I do not  
12 believe that it is C.F.R. based. But there are a  
13 number of free-standing eating disorder programs  
14 that are there that are not available for our  
15 beneficiaries, and that has been an issue, too. I  
16 think the individual outpatient chemical  
17 dependency treatment is definitely an issue. And  
18 then the various levels of care that other payors  
19 actually will offer that TRICARE does not, and  
20 those would be the things that I would focus on.  
21 DR. MCCORMICK: The word parity has been  
22 used. Let me just clarify one thing. Are we

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1 correct in our understanding that there are limits  
2 on the number of psychiatric inpatient days per  
3 year, while there are not limits on the number of  
4 medical days per year? If that is true, is that  
5 really a big thing for you guys?

6 DR. PROCTOR: The structure of the  
7 facility-based mental-health benefit does have a  
8 limit on inpatient days, RTC days, and partial  
9 days. There are also some limits on these  
10 outpatient substance abuse groups, but those are  
11 primarily the top three. These are waiverable,  
12 and the way the regulation reads, in special  
13 circumstances, when there are new diagnostic  
14 considerations, when are new treatment plan  
15 considerations. So it is a limit, but it is  
16 waiverable. The way it could be viewed is there  
17 is just a little bit higher threshold, something  
18 new is going on and there are certain aspects of  
19 this case in which a waiver would be appropriate.  
20 The regulation actually reads that there is a  
21 statutory presumption against waiving it, but it  
22 is able to be done.

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1 DR. MCCORMICK: One last question. A

3 deploying so many Reserve components as we heard  
4 before, is the reality that a family member may be  
5 living in a small town where there is a provider  
6 that provider might not have very much experience  
7 with what military stresses are like and military  
8 issues are like? What if anything do you do to  
9 try to up-educate providers who do not have a lot  
10 of experience with combat stress and things like  
11 that?

12 DR. PROCTOR: In the initial  
13 credentialing and education, we do tell them about  
14 the benefit and all the requirements, we did send  
15 out to all of our network providers in 2005 a  
16 mailing on posttraumatic stress disorder in  
17 particular with regard to recognition, and to  
18 treatment. That is primarily what we have done to  
19 date.

20 DR. MACDERMID: Are there any other  
21 questions from members of the task force? If not,  
22 I think you are out.

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1 DR. PROCTOR: Thank you.

2 (Applause)

3 LTG KILEY: Thank you very much.

4 According to our schedule, this ends this session  
5 of the public open session. We will close and

6 take a 5-minute break and then go into executive  
7 session. We are scheduled to reopen at about  
8 12:50 today for one more brief TRICARE  
9 reimbursement on a conference call. Then tomorrow  
10 for those in the audience, we have a whole series  
11 of presentations from both special interest groups  
12 and DOD starting at 8 o'clock in the morning in an  
13 opening session. So that is it. Thank you.

14 (Recess)

15 DR. MACDERMID: It looks like everybody  
16 is seated and ready to go, so I will rap the  
17 gavel. Welcome to this session of the DOD Task  
18 Force on Mental Health. For those who were not  
19 here yesterday, this is a congressionally mandated  
20 task force asked to look into the current military  
21 mental-health system. The overall intent of our  
22 meeting here today is to gain insight into that

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1 system and ultimately provide Congress with  
2 recommendations for areas of improvement, but also  
3 to acknowledge areas that are flourishing. We  
4 have asked specific speakers to present to the  
5 task force because we are particularly interested  
6 in their programs and experience. Let's go around  
7 the room and introduce ourselves.

8 COL CAMPISE: Good afternoon. I am Rick  
9 Campise. I am a pediatric psychologist. I am in

10 Washington DC 20061219 TF meeting transcripts FINAL.txt  
charge of deployment behavioral health with the  
11 Air Force Surgeon General's Office.  
12 MS. FRYAR: Good afternoon. I am  
13 Deborah Fryar, the family member representative to  
14 the task force.  
15 COL DAVIES: Good afternoon. I am  
16 Colonel Jeff Davies, the alternate designated  
17 federal official for the task force.  
18 DR. MCCORMICK: I am Dick McCormick, a  
19 clinical psychologist, a civilian member of the  
20 task force.  
21 CAPT MACEACHERN: Good afternoon. I am  
22 Captain Margaret MacEachern, a Navy child and

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1 adolescent psychiatrist.  
2 MS. POWER: I am Kathryn Power, the  
3 Director of the Center for Mental Health Services  
4 at the Department of Health and Human Services.  
5 LTC DOUGLAS: I am John Douglas,  
6 Headquarters, Marine Corps Manpower and Reserve  
7 Affairs.  
8 DR. MACDERMID: I am Shelley MacDermid.  
9 I am an associate dean in the College of Consumer  
10 and Family Sciences at Purdue University.  
11 DR. ZEISS: I am Dr. Antoinette Zeiss.  
12 I am the Deputy Chief Consultant in the Office of  
13 Mental Health Services at Department of Veterans

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14 Affairs, and I represent VA on the task force.

15 COL ORMAN: I am Dr. Dave Orman. I am a  
16 psychiatrist in the Army. I travel full-time in  
17 support of the task force site visits.

18 LCDR WERBEL: I am Dr. Aaron Werbel. I  
19 am a clinical psychologist and I am the Behavioral  
20 Health Affairs Officer at Headquarters, Marine  
21 Corps.

22 CAPT KLAM: I am Dr. Warren Klam. I a

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1 child and adolescent psychiatrist. I am the  
2 Navy's Psychiatry Special Leader.

3 COL PEREIRA: Good afternoon. I am Dr.  
4 Angela Pereira, social work representative to the  
5 task force.

6 DR. MCCURDY: I am Layton McCurdy, a  
7 clinical psychiatrist and a civilian member of the  
8 task force.

9 DR. BLAZER: I am Dan Blazer, a  
10 psychiatrist/epidemiologist from Duke University.  
11 I am also on the Defense Health Board and not only  
12 serving on the task force but in liaison between  
13 the Defense Health Board and the task force.

14 DR. MACDERMID: Dr. Burke, do you have  
15 any administrative comments for us?

16 DR. BURKE: Yes. Thank you, Dr.  
17 MacDermid. I would like to welcome everyone to

Washington DC 20061219 TF meeting transcripts FINAL.txt  
18 the afternoon session. For those attendees who  
19 have not done so already, please sign the general  
20 attendance roster on the table near the front  
21 door. We will be transcribing this open session,  
22 so please use microphones when speaking and

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1 clearly state your name. The transcripts will be  
2 published on the task force's Website within 90  
3 days of this meeting. We would also like to ask  
4 those who make comments to be respectful of their  
5 fellow persons here and allow those who are  
6 speaking courtesy and respect. Restrooms are  
7 located outside the main door on the right, and  
8 for any administrative requirements, please see  
9 Ms. Bennett at the front door, or Ms. Farrell who  
10 is taking care of audiovisual. Thank you, Dr.  
11 MacDermid.

12 DR. MACDERMID: Thank you, Dr. Burke.  
13 Ms. Ellen Embrey, the designated federal official  
14 for the task force's parent, the Federal Advisory  
15 Committee, the Defense Health Board, had an  
16 unavoidable conflict and will not be able to  
17 attend this meeting. In her absence she has  
18 appointed Colonel Jeffrey Davies, the Army's  
19 Surgeon General Executive Officer as the alternate  
20 designated federal official. Colonel Davies,  
21 would you like to call this open session of the

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22 task force to order?

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1 COL DAVIES: Dr. MacDermid, yes, I  
2 would, and as the acting designated federal  
3 official for the Defense Health Board, a federal  
4 advisory committee to the Secretary of Defense and  
5 it serves as a scientific advisory body to the  
6 Assistant Secretary of Defense for Health Affairs,  
7 as well as the Surgeons General of the military  
8 departments, I hereby call this meeting to order.

9 DR. MACDERMID: I believe while we were  
10 going through these introductions I heard the  
11 little chirp on the phone that signals that our  
12 speakers have arrived. Am I correct? Is there  
13 someone on the phone?

14 MS. COVIE: Yes, you are correct. This  
15 is TRICARE Management Activity and we are located  
16 in Aurora, Colorado.

17 DR. MACDERMID: Let me mention to  
18 members of the audience in attendance that Mr.  
19 Michael O'Bar is here in person, Ms. Chris Covie  
20 and Mr. Stan Regensburg will be presenting via the  
21 telephone. We have it miked, so everybody will be  
22 able to hear it. We welcome our speakers. Please

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1 go ahead.

2 MS. COVIE: Good afternoon. This is  
3 Christine Covie from TRICARE Management Activity.  
4 I am here to do a brief introduction. I'm sorry,  
5 I need to introduce our panel members. I have  
6 Stan Regensburg and Mr. Dave Bennett, as well as  
7 myself, and were asked to address the issue of  
8 mental-health reimbursement. I do not want to  
9 take Mike O'Bar's thunder, so we are going to turn  
10 it over to him.

11 MR. O'BAR: Thank you, Christine. Good  
12 afternoon, and I appreciate the opportunity to  
13 appear here before the task force and hopefully  
14 adequately address your concerns which I  
15 understand primarily in our portion of the  
16 presentation here are having to do with our  
17 TRICARE reimburses for mental-health services.

18 I am assigned to the TRICARE Management  
19 Activity and work in the TRICARE Operations  
20 Section and head up what is called the Benefits  
21 Division there. As a collateral duty, I am  
22 currently leading a work group on behavioral

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1 health that our deputy director at TRICARE

2 established in response to correspondence he  
3 received in June from the TRICARE regional office  
4 director in the North region that had been  
5 coordinated with the other two regional directors,  
6 the South director and the West director, that  
7 asserted that we were unable to obtain and retain  
8 in our private-sector care network adequate  
9 numbers of partial hospitalization programs,  
10 SUDRUF, and RTC facilities to satisfy the needs of  
11 beneficiaries. The assertion also attributed this  
12 to the reimbursement rates that we used, as well  
13 as to the TRICARE certification requirements.

14 Major General Granger's reaction to that  
15 was that there was not enough data along with the  
16 assertion to support it and so he established the  
17 work group to go out and try to gather facts to  
18 see whether or not the hypothesis that had been  
19 asserted by the TRICARE North regional director  
20 could be supported. The work group has had two  
21 meetings and are very much in the midst of the  
22

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1 data-gathering effort at this point, so we really  
2 do not have any conclusions that we have reached  
3 that we could share, and we certainly have not  
4 even reported out to Major General Granger yet.

5 The folks you will hear from on the

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6 phone here, as Christine Covie mentioned, are at

7 our TRICARE Management Activity facility in  
8 Aurora, Colorado, and Christine and Stan  
9 Regensburg work in the medical benefits and  
10 reimbursement systems offices so they are very  
11 much the experts on the details of how we actually  
12 reimburse for mental-health services.

13 DR. MACDERMID: I am sorry to interject  
14 so early, but when do you anticipate that this  
15 work group will have information that they could  
16 share?

17 MR. O'BAR: I would think in a month and  
18 a half or 2 months.

19 DR. MACDERMID: And you will make sure  
20 that that gets to the task force?

21 MR. O'BAR: Through General Granger,  
22 certainly.

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1 DR. MCCORMICK: Could I just ask a  
2 process question on that same thing? If you did  
3 in fact find out that there were issues with  
4 either reimbursement or the accreditation process,  
5 who would have the authority to make remedy to  
6 that? Would that require a change in law, a  
7 change in regulations, or would the major general  
8 that you mentioned have the authority to actually  
9 do something about that?

10 MR. O'BAR: I think it would depend on  
11 what kind of recommendations were made for  
12 changing either of those. Some of those changes  
13 would be within our authority, some of them are in  
14 law, and some of them are actually operationalized  
15 in the Code of Federal Regulations.

16 DR. MACDERMID: I am pointing to the  
17 phone, so if you would like to speak up, we are  
18 anxious to hear from you.

19 MS. COVIE: Is that a segue to TMA  
20 Aurora?

21 DR. MACDERMID: Yes, I think so.

22 MS. COVIE: I would like to introduce

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1 momentarily our Division Director. Rita Micek (?)  
2 is here with us and will help be providing  
3 information as well. I think Rita would like to  
4 make a few comments at first concerning the depth  
5 of material we are addressing. We have plenty of  
6 details and probably could talk ad infinitum about  
7 reimbursement. So please feel free to let us  
8 know. If we may have skipped something or you  
9 require something after the fact, we are more than  
10 happy to comply. With that, this is Rita Micek.

11 MS. MICEK: Good afternoon. What we are  
12 planning today is go over some historical  
13 background information on how the various rates

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14 have been established and why they were  
15 established the way they are, and then to also  
16 talk about how we do annual updates, how we differ  
17 or how we are the same as Medicare. Hopefully  
18 that will give you a broad enough background, and  
19 we certainly are here to answer any questions. If  
20 that is not what you are looking for, please let  
21 us known, but that is the approach we are taking,  
22 to try to just give you a broad overview of our

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1 reimbursement policies for mental-health care.  
2 MS. COVIE: If there are not any  
3 questions, I think we will get started. We will  
4 start with the historical developments of  
5 inpatient mental health. Stan Regensburg is going  
6 to go ahead and talk about that.  
7 MR. REGENSBURG: Before I start, we are  
8 going to be looking at inpatient mental-health  
9 reimbursement, also partial hospitalization  
10 reimbursement, and residential treatment center  
11 reimbursement. I will be talking about the  
12 inpatient mental health and how that all came  
13 about and how we pay for those inpatient services.  
14 In 1988 we drafted a proposed and final  
15 rule concerning our reimbursement system for the  
16 payment of mental-health services in psychiatric  
17 hospitals and psychiatric units in acute care

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18 hospitals. The official effective date was  
19 January 1, 1989, where the admissions to these  
20 facilities were to be paid under this per diem  
21 payment system. Let me step back and say that  
22 prior to that we paid billed charges to these

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1 facilities because we did not have a reimbursement  
2 system developed at that time, or acute care  
3 hospitals, if a patient is admitted to an acute  
4 care hospital and that hospital does not have a  
5 psychiatric unit, the treatment that is rendered  
6 in that acute care hospital would be paid under  
7 our DRG reimbursement system, and our DRG  
8 reimbursement system is patterned after Medicare's  
9 reimbursement system. It is based on diagnostic-  
10 related groups and this system is updated every  
11 year around October 1. We follow the same update  
12 process that Medicare uses for that DRG  
13 reimbursement system.

14 However, in the case of psychiatric  
15 hospitals and psychiatric units that are in these  
16 acute care hospitals, Medicare excepted these  
17 facilities from their prospective payment system  
18 which was a DRG reimbursement system, and since  
19 TRICARE and at that time CHAMPUS did so much  
20 business with these facilities, we decided that we  
21 needed to develop our own reimbursement system and

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22 this system was developed based on per diems on a

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1 per day payment. Those rates were based on  
2 charged data from CHAMPUS charges that we had  
3 received from these psychiatric hospitals and  
4 psychiatric units.

5 The development of the proposed and  
6 final rule were laid out and we had very close  
7 contact with the American Psychiatric Association  
8 in coming up with the system that was finally  
9 decided on in our final rule. They helped us in  
10 identifying what they felt we ought to include in  
11 our payments and what would work for the  
12 government, and they were very influential in  
13 helping us develop our reimbursement system.

14 As I said, the payment system is based  
15 on per diem rates. Under the per diem rates we  
16 have two categories of providers. We have what is  
17 called a high-volume category of providers, and a  
18 low-volume category of providers. Those that fall  
19 into the high volume category have 25 or more  
20 discharges in a federal fiscal year, and by so  
21 doing, they qualify for a high-volume hospital-  
22 specific per diem rate. The low-volume providers

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1 are just the opposite. They have less than 25  
2 TRICARE discharges in a federal fiscal year and  
3 they have a rate based on what we call a regional  
4 rate.

5 Let me look at the high-volume and give  
6 you some information about those per diems. The  
7 high-volume rate is specific and has been  
8 established specifically for the provider based on  
9 TRICARE charge data. Those rates are all-  
10 inclusive for the most part. That means that they  
11 would include all the services and costs of the  
12 high-volume provider. There may be some  
13 exceptions regarding professional services, and  
14 those could be billed separately depending on the  
15 billing practices of that facility. Once a  
16 provider has been identified by TRICARE as high-  
17 volume, they remain in that category. They cannot  
18 lose that status as high-volume.

19 In the case of the low-volume provider,  
20 as I mentioned, we have regional rates. We have  
21 nine regions. These regions were based on the  
22 federal census regions. We felt at the time, and

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1 this was agreed to by the American Psychiatric

2 Association, that these regions that had been  
3 established by the federal Census Bureau, all of  
4 the states within that region are located in a  
5 specific area and it was easy for us to keep that  
6 data for those states in coming up with a rate for  
7 that region. There is a little difference for the  
8 low-volume providers. The regional rates are  
9 further adjusted for a facility in a certain area.  
10 For instance, a facility in Atlanta, Georgia,  
11 would get what we call an area wage adjustment  
12 that would be different than maybe a rural area of  
13 Georgia. That adjustment is applied to the  
14 regional rate for the specific facility. In  
15 addition to that, we have an adjustment for  
16 indirect medical education for those hospitals  
17 that may have connection with a teaching program.  
18 They get an additional adjustment for that to  
19 cover that cost.

20 Also the regional rates are adjusted or  
21 get some additional payment for direct medical  
22 education costs. These three adjustments are

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1 different than the high-volumes. High-volumes do  
2 not participate in these adjustments.

3 You may be asking where did we come up  
4 with the adjustments. The adjustments came from  
5 our DRG reimbursement system. The DRG

6 reimbursement system also has adjustments for area  
7 wages, indirect medical education, and so we just  
8 patterned those adjustments for the regional rates  
9 for the low-volume providers and for the DRG  
10 reimbursement system.

11 As I indicated, the facilities that come  
12 under the mental-health per diem payment system  
13 are those that are exempt from the Medical  
14 prospective DRG reimbursement system, and the  
15 services, the admissions to these facilities would  
16 fall under what we call DRG's 425 to 432, this is  
17 the mental-health DRG; 433 to 437 are the  
18 substance use disorder DRGs; and then we added 900  
19 and 901 DRGs that would also come into play for  
20 these facilities under the per diem payment  
21 system.

22 LCDR WERBEL: I have a question if you

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1 can hear me on the phone.

2 MR. REGENSBURG: Sure.

3 LCDR WERBEL: Fully cognizant of the  
4 fact that there is quite a range here we are  
5 talking about between the high and low probably  
6 and with all the adjustments, on average how do  
7 those compare to the Medicare-based reimbursement  
8 rates, higher or lower?

9 MS. COVIE: I am prepared to handle that

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question if we have time to go over a Medicare

overview. We are pretty close, neck and neck,  
depending on if you are looking at high- volume  
versus low- volume, and we have conducted analysis  
to compare and contrast the two.

LCDR WERBEL: So it is about the same?

MS. COVIE: Pretty close, depending on  
which geographic region you look at. Is your  
question referencing to the inpatient rates or to  
the PHP rates?

LCDR WERBEL: We are just talking about  
inpatient so far.

MS. COVIE: I apologize. Let me jump

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ahead to my notes. When we conducted our  
analysis, the average cost of a TRICARE stay was  
\$615 per diem. On the Medicare scale it was \$639.  
So we are within \$25, if you will, of an average  
per diem.

MR. REGENSBURG: One thing that I did  
not mention, the high- volume per diems, even  
though they are hospital- specific, we do have a  
cap amount that is figured at the seventieth  
percentile. So even though a hospital- specific  
per diem may be greater than that, the  
reimbursement system has a cap at that seventieth  
percentile of the high- volume rates.

14 Leave days are not paid for. If a  
15 patient would leave the facility, the system does  
16 not pay for leave days because their thinking is  
17 that this is an acute situation and if they are  
18 able to leave then they are probably not needing  
19 the acute care anymore so that becomes a discharge  
20 and the patient would be readmitted or put into a  
21 partial hospitalization program. I understand  
22 that that cap amount that I was just talking

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1 about, currently it is \$832 a day.  
2 Let me mention that a part of this  
3 reimbursement system as we laid it out and as I  
4 indicated received coordination and approval from  
5 the American Psychiatric Association, we wanted to  
6 make sure that our rates remained current, and so  
7 it was linked on an annual basis updating those  
8 rates based on Medicare's final rule of updating  
9 providers that were exempt from their DRG  
10 reimbursement system which as I mentioned are  
11 these psychiatric hospitals, psychiatric units,  
12 and acute care hospitals. So we have maintained  
13 increases ever since implementation in 1989 and  
14 rates have gone up across the board based on these  
15 rates of cost increases.  
16 I wanted to mention that the per diem  
17 rates were established based on charges.

18 Historically, charges are higher than a provider's  
19 cost. So we put this cushion in there to base our  
20 charges for our per diems based on charges and not  
21 cost. This was one of the issues that the  
22 American Psychiatric Association definitely

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1 wanted, was to base our per diems on charges and  
2 not cost. So those costs for those charged per  
3 diems as I had indicated have been increased on an  
4 annual basis since 1989.

5 If we have a new facility that comes  
6 onboard as an authorized provider, we bring them  
7 into the reimbursement system. Once they attain  
8 25 or more discharges in a federal fiscal year,  
9 they can attain that high-volume status. I wanted  
10 to mention that in this reimbursement system that  
11 we have a deflator factor that when the new  
12 facility rate is established, the mechanism that  
13 we have in place deflates the current rate for  
14 that facility back to the beginning, back to 1989,  
15 and then we update that rate using update factors  
16 that I have mentioned every year to the current  
17 time so every facility is on the same plane or  
18 benchmark, as you might say, back to 1989 and then  
19 all rates have been adjusted upward since 1989,  
20 including these new facilities.

21 I really do not have any further

Washington DC 20061219 TF meeting transcripts FINAL.txt  
22 information. If there are any specific questions,

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1 we will try to answer you.

2 DR. MACDERMID: I do not see any at this  
3 point. Should we move on them to partial  
4 hospitalization? Is that the plan? Outpatient,  
5 sorry.

6 MS. COVIE: This is Christine Covie, and  
7 I would like to address our payment system under  
8 our SUDRUF program. Our SUDRUF program is for  
9 inpatient mental-health substance abuse stays and  
10 that is paid on a DRG basis. Short and sweet. We  
11 pay that under the DRGs, and all the information  
12 that Stan mentioned applicable to our DRG system  
13 is also applicable to how we pay SUDRUF. Dave, do  
14 you want to go on to RTC?

15 MR. BENNETT: I will give you a brief  
16 background about our residential treat center  
17 reimbursement system. I am going to start back in  
18 the 1960s. Before we established the criteria for  
19 a medical model for our RTCs, we had some 2,200  
20 facilities nationwide. These were mostly mom and  
21 pop organizations. However, there were a lot of  
22 instances during that time period of a lot of

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1       abuse. Congress stepped in with the Jackson  
2       Reports and that is when the program initiated a  
3       lot of safeguards, and one was to use the Joint  
4       Commission Consolidated Standards and we moved  
5       toward the medical model type of program.  
6               It drastically reduced the number of  
7       RTCs in our program, and it was hovering around  
8       120 for a good part of the time. We did not have  
9       any problems recruiting because we were paying  
10      billed charges, and also Congress was looking at  
11      the expenditures every year and it was noted that  
12      they were skyrocketing. So in the 1970s we  
13      decided to go with a proposed and final rule  
14      making and the agency wanted the most favored  
15      rate. This got caused a lot of concerns by the  
16      RTCs because the RTCs had a lot of state contracts  
17      so this was going to cause some hardships for  
18      them. So they went to court and went through a  
19      legal battle over about a 6-month period. We were  
20      enjoined, and out of that settlement, our current  
21      reimbursement methodology was ironed out and  
22      actually it was placed into the regulation. It

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1       was very specific and it was out of that

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2 settlement agreement. So we said we do not want

3 (interruption) but we will give you a rate at  
4 33-1/3 percent or one-third of your patients at  
5 that rate above which 33-1/3 percent of our  
6 patients are currently being paid. So the  
7 methodology was, during that period we simply  
8 arrayed all the third-party payors with the number  
9 of patient days for each one of those third-party  
10 payors and went to 33-1/3 percent up the line and  
11 whatever they were paying at 33-1/3 off of that  
12 array, that was what our rate was going to be. It  
13 was an all-inclusive rate. It included both  
14 professional charges and facility charges. The  
15 things that could be paid outside the rate, and  
16 these were only under special circumstances, were  
17 educational rates and also geographically distant  
18 family therapy, that if the family is over 200  
19 miles we would pay for the family therapy.

20 After implementation of this and until  
21 we went to the managed care, we were running  
22 anywhere from 85 to 90 facilities nationwide.

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1 With TNEX managed care support contracts, the  
2 utilization dropped drastically because of the  
3 utilization drop and I do not think it was because  
4 of the rates. But because of utilization drop it  
5 has been hovering around anywhere from 45 to 55

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6 facilities nationwide. So currently have that

7 methodology in effect for all new facilities that  
8 come in for participation in our program. As it  
9 stands, it is 33-1/3 percent of accepted rates for  
10 third-party payors and it is subject to a cap  
11 amount that has also been maintained since that  
12 original base period. We use that as a cap amount  
13 for limiting their payments. Again, this is in  
14 the regulation. Any changes in this methodology  
15 would require a rewrite of the regulation. That  
16 is it for an historical background. If somebody  
17 has some questions, I would be happy to answer  
18 them.

19 LCDR WERBEL: Just to make sure I heard  
20 you correctly, the procedure we are using now for  
21 determining rates was developed in the 1970s?

22 MR. BENNETT: Yes. Our methodology, our

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1 initial base period, was July 1, 1987, through  
2 June 3, 1988. From the 1970s to the 1980s and  
3 into the 1980s we paid billed charges.

4 LCDR WERBEL: Do you know why the  
5 decision was 33-1/3?

6 MR. REGENSBURG: An analysis was done  
7 and we were just looking at the different rates.  
8 At that time we took an whole array. We had a  
9 study group or an outside contractor do an

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10 evaluation during that time period and they were  
11 looking at 15, 20, to 25, and they took a whole  
12 array of the proportion of days and it was found  
13 that if we set them at 33-1/3 percent that most  
14 all of the state contracted rates fell below that,  
15 so we felt that if we could keep above the state  
16 rates that the program would not be subsidizing  
17 state programs, that we would be in the private or  
18 other third-party sector at that level.  
19 LCDR WERBEL: Just to be sure I  
20 understand what the 33-1/3 was, I think I do, it  
21 was that you looked at all of the rates that were  
22 being charged or all of the different

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1 reimbursement rates you saw out there in the  
2 country and lined them up and you set the  
3 reimbursement rate at 33-1/3 percent of that  
4 range?  
5 MR. REGENSBURG: Of those days, yes, but  
6 they were specific for the facility. So if you  
7 had a facility and 25 percent of the days were at  
8 state contracted rates and then the next was Blue  
9 Cross/Blue Shield and they had 15 percent of their  
10 total yearly days were at Blue Cross/Blue Shield,  
11 and you would array them from lowest to highest as  
12 far as dollar amounts or per diem amounts. Then  
13 you would go up into the number of days, and the

14 number of days is 33-1/3 percent was the per diem  
15 rate that we adopted.

16 DR. MACDERMID: I am still a little  
17 fuzzy on this. You said it was the rate -- 33-1/3  
18 percent were above that rate?

19 MR. REGENSBURG: I'll just give you an  
20 example. Let's say we had five third-party payors  
21 in Oklahoma and the State of Oklahoma was the  
22 lowest rate and 25 percent of their total days in

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1 a given calendar year were at that state rate.  
2 Then we had Blue Cross/Blue Shield which is the  
3 next payor at the next rate up, let's say one was  
4 at 225, the next one was at 250, and those counted  
5 for 15 percent of the total days. The cumulative  
6 days would be 35 percent. So we would go in at  
7 33-1/3 percent of the cumulative days and that  
8 would be at the Blue Cross/Blue Shield rate which  
9 would be the 250.

10 LCDR WERBEL: While she is thinking, let  
11 me ask a question that is not as much about those  
12 kinds of numbers. First of all, when you talk  
13 about residential treatment, is the bulk of that  
14 for substance abuse care, or what percentage of  
15 that is for substance abuse care?

16 MR. REGENSBURG: Very little.

17 MS. MICHAK: This is Rita. RTC is

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18 psychiatric care for children and adolescents, so  
19 substance abuse treatment could be a component,  
20 but not the reason they are in there.  
21 MR. REGENSBURG: The most common  
22 disorder back there, and this is the old judgment

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1 (interruption)  
2 LCDR WERBEL: You also said that the  
3 number of facilities dropped from 85 to 90, to 45  
4 to 55, and that your understanding of that drop  
5 off was not that it was related to the  
6 reimbursement rate. If it was not related to the  
7 reimbursement rate, what did you hypothesize it  
8 was related to?  
9 MR. REGENSBURG: Since we have the  
10 managed care contractors, they were not  
11 authorizing care in RTCs, they were authorizing  
12 care at partial hospitalization and outpatient  
13 settings.  
14 MS. COVIE: I think one thing to keep in  
15 mind is during that time our contractors were at-  
16 risk contractors, and certainly where they could  
17 provide care at a lesser level of care and where  
18 that is available with mental health, then people  
19 just were not admitted for RTC care, they were  
20 admitted and received care at a less-intensive  
21 level.

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1 people with more questions, but I want to check.  
2 Do you have more material that you want to present  
3 to us?  
4 MS. COVIE: We do.  
5 DR. MACDERMID: Why don't you go ahead  
6 and do that then?  
7 MS. COVIE: We need to quickly cover the  
8 partial hospitalizations.  
9 MR. REGENSBURG: This is Stan Regensburg  
10 again. I will attempt to tell you about partial  
11 hospitalization reimbursement and what was the  
12 basis for that. The partial hospitalization rates  
13 were derived from the per diem reimbursement  
14 system. It was a kind of piggyback on the rates  
15 that we had established for the per diem for the  
16 psychiatric hospitals and the psychiatric units.  
17 As to the percentages of how those rates were  
18 established, I will just read a sentence for you.  
19 First of all, I want to tell you that we have two  
20 rates again for partial hospitalization. We have  
21 a rate for a minimum of 6 hours which would mean 6  
22 or more hours, and then we would have a rate for

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1 under 6 hours, a 3- to 5-hour per diem rate. We  
2 call the minimum of 6 hours a full day partial  
3 rate, and then the 3 to 5 hours would be I guess  
4 less than the full-day rate, like a half day is  
5 what we would consider that to be.

6 Let me tell you how that per diem rate  
7 for the full day is determined. If the maximum  
8 per diem payment amount is 40 percent of the  
9 average inpatient per diem amount per case paid to  
10 both high- and low-volume psychiatric hospitals  
11 and units, would be the federal census region  
12 during fiscal during 1990. Again, the federal  
13 census regions is what I talked about earlier that  
14 were used in the establishment of the low-volume  
15 mental-health rates.

16 Then for the half-day rate, it was to be  
17 based on 75 percent of the full-day rate. So we  
18 established the full-day rate, and then we took 75  
19 percent of that full-day partial hospitalization  
20 rate and that became the half-day rate. Again I  
21 want to stress that these rates for  
22 hospitalization also linked to the update factors

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1 that we used for the psychiatric hospitals and

3 updating the rates for partial hospitalization to  
4 keep up with the cost of providing this care.

5 The partial hospitalization rates were  
6 designed to be all-inclusive. When I say all-  
7 inclusive, psychotherapy sessions will be included  
8 in the treatment program. The only exception had  
9 to do with the attending provider -- if the  
10 attending provider linked up with the partial  
11 hospitalization program, he was able to continue  
12 to stay abreast of what was going on in the  
13 program and provide care within that partial  
14 program and he was able to bill for his services  
15 outside of those rates that were established under  
16 the partial program. Like I say, the intent was  
17 that this was an all-inclusive rate and all  
18 services that were provided to the patient in the  
19 partial program and under these rates is all-  
20 inclusive.

21 MR. BENNETT: Also I just wanted to  
22 interject this. On June 1, 2007, we are going to

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1 the outpatient prospective payment system. These  
2 are for hospital outpatient services. So for all  
3 hospital PHP programs, we will convert over to an  
4 ambulatory classification grouping under Medicare  
5 and so those partial programs will be paid under

6 those outpatient prospective amounts that Medicare  
7 has established. Medicare, however, only has a  
8 full-day program, so we have just simply developed  
9 our own APC rate for half-day. Again, we are just  
10 using 75 percent of the full partial  
11 hospitalization rate to cover that half-day  
12 program

13 DR. MACDERMID: In general, would those  
14 rates be lower than what they are now?

15 MR. BENNETT: They are pretty  
16 comparable. Looking at them, they were within a  
17 couple dollars of each other. The rates that we  
18 are using under the per diem rate and the rates  
19 under the APC were very close.

20 DR. MACDERMID: There are some folks in  
21 the group here who are really anxious to hear  
22 about reimbursement for outpatient care. Is that

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1 something that you had planned to talk about  
2 today?

3 MR. BENNETT: I think that was beyond  
4 the scope of this.

5 MS. COVIE: I think we can cover  
6 basically what our rules are for all the charges.

7 MR. REGENSBURG: First of all, the  
8 partial hospitalization program was designed to  
9 treat the patient on an outpatient basis. In

10 other words, if a patient is to be seen and  
11 treated as an outpatient, the patient was to come  
12 under the partial hospitalization program. If the  
13 patient receives this type of care (interruption)  
14 provider on an outpatient basis, that is all it  
15 appears that they really need is their  
16 psychotherapy from their attending provider, then  
17 those services of the attending provider are paid  
18 under our CHAMPUS maximum allowable charges for  
19 the services that are rendered there.

20 Let me go a little further. The CHAMPUS  
21 maximum allowable charges relate to professional  
22 services of psychiatrists and psychologists,

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1 social workers, mental-health counselors and so  
2 on, and these rates again are updated annually and  
3 are linked to the Medicare reimbursement system  
4 for professional services. We group the  
5 psychologists and psychiatrists in what we would  
6 call the physician grouping, and then all other  
7 providers come under a separate heading of the  
8 nonphysician in that group and their rates are  
9 established based on 75 percent of what the rate  
10 would be for a psychiatrist/psychologist grouping.

11 COL PEREIRA: Are we still talking about  
12 partial hospitalization?

13 MR. REGENSBURG: No. We are talking

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14 about a patient who may have been discharged from  
15 a hospital and has chosen not to be treated in a  
16 partial hospitalization program and is being  
17 treated by their attending provider, psychotherapy  
18 or whatever group and other type of mental-health  
19 services that that patient might receive on an  
20 outpatient basis other than the partial  
21 hospitalization program.  
22 COL PEREIRA: But as part of the

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1 discharge plan with continuing treatment after  
2 hospitalization?  
3 MR. REGENSBURG: I'm sorry, could I hear  
4 that again, please?  
5 COL PEREIRA: After discharge from  
6 hospitalization, you are talking about continued  
7 treatment, are those the same rates that apply on  
8 a purely outpatient basis if you were to come in  
9 for psychotherapy?  
10 MR. REGENSBURG: Those would be the  
11 professional services that the TRICARE program  
12 would pay for an outpatient basis.  
13 COL PEREIRA: So they are different.  
14 Can you talk about those, just purely outpatient  
15 rates?  
16 MR. REGENSBURG: I am not quite  
17 understanding what you mean by strictly outpatient

18 Washington DC 20061219 TF meeting transcripts FINAL.txt  
rates.

19 SPEAKER: It is the outpatient rate.

20 COL PEREIRA: They are the same rate.

21 It is the outpatient rate. Say again, please,

22 what that is based on? Seventy-five percent of

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1 what?

2 MR. REGENSBURG: Let me back up a little  
3 bit. Professional services that are rendered on  
4 an outpatient basis outside of the partial  
5 hospitalization program for professional services,  
6 we have two groupings of providers. One group is  
7 a physician, in this case a psychiatrist and a  
8 psychologist group, and then we have a second  
9 group which is what we call nonphysicians, social  
10 workers, nurses, counselors, that type of provider  
11 would fall into that group.

12 For the psychotherapy or other mental-  
13 health treatment that is being provided by these  
14 providers, for the rate that we have for those  
15 services, we adopt the Medicare rate for those  
16 services, and for the second category, the  
17 nonphysician category, the rate for those  
18 nonphysicians are 75 percent of the physician  
19 category. I will give you an example. Let's say  
20 that the physician rate is \$100, the allowable  
21 amount is \$100, the allowable amount for the

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nonphysician group would be \$75.

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1 COL PEREIRA: Do you have any  
2 flexibility in adjusting those rates in areas  
3 where it is hard to recruit providers?

4 MR. REGENSBURG: We do, but not for  
5 recruitment. We do not recruit providers and  
6 change rates to recruit providers. We have the  
7 authority to change or raise rates if there is a  
8 severe access to care problem.

9 COL PEREIRA: How and when does that  
10 happen? We have heard in the field that many  
11 times there are providers in a community, but they  
12 will not take TRICARE patients because the  
13 reimbursement rates are too low.

14 MR. REGENSBURG: In our office in  
15 Aurora, Colorado, we have direct links with what I  
16 am sure you understand is our TRICARE regional  
17 offices. Those people are Johnny-on-the-spot as  
18 you would say to identify issues where we are  
19 having problems getting providers to treat our  
20 beneficiaries. They would let us know that they  
21 are having issues in getting providers in networks  
22 or providers to treat our patients under standard

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1 TRICARE, and we would review those allegations or  
2 comments based on supporting documentation, and  
3 from that supporting documentation a decision will  
4 be made as to whether we had a severe access  
5 problem that existed and that that severe access  
6 was directly related to the reimbursement rates.

7 If it is for other issues and not  
8 reimbursement rates, then we need to look at those  
9 other issues. If it is directly related to  
10 reimbursement rates, then we need to make sure  
11 that before we raise any rates that we will be  
12 able to get the care that we need in order to  
13 treat the beneficiaries in that specific locality.

14 COL PEREIRA: It sounds fairly  
15 straightforward. It is surprising that it is not  
16 done more frequently. Can you tell us why those  
17 rates are tied to Medicare rates? Or in many  
18 cases it sounds like only 75 percent of Medicare  
19 rates which is for us, that is a system that was  
20 designed to provide for an indigent population for  
21 the most part. Right now what we are looking at  
22 is paying for services that are for our armed

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1 forces members and their families that are at a

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2 very low rate. Could you talk a little bit to

3 that?

4 MR. REGENSBURG: Let me say that the  
5 reason we follow and adopt the Medicare payment  
6 allowable rates that they have established is that  
7 statutorily the Congress said that TRICARE was to  
8 adopt rates and reimbursement that CMS has  
9 established where practicable, and that is the  
10 authority that we have and that we are under,  
11 using those Medicare rates.

12 DR. MCCURDY: You may not have an answer  
13 for this, but I am curious about what portion of  
14 TRICARE out-pay is directed to outpatient care and  
15 what percentage is directed to all the other  
16 services which we have talked so much about this  
17 afternoon?

18 MS. COVIE: We currently do not have the  
19 statistics that you have asked for. If I am  
20 understanding correctly, you want to know within  
21 our bucket of mental health care expenses how much  
22 we pay on the acute side, versus how much we pay

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1 for example the PHP side, versus how much we pay  
2 for strictly outpatient counseling?

3 DR. MCCURDY: What we have heard in the  
4 field, I have heard no complaints about the  
5 reimbursement or lack of access to inpatient care.

6       There have been some problems associated with  
7       partial hospitalization, but for the most part  
8       here is that the outpatient treatment rates are  
9       not competitive and that as a result of that,  
10      clients, recipients, dependents, cannot gain  
11      access to the treatment that they need, and more  
12      and more and more often we hear it has to do with  
13      the rates.

14               MS. COVIE: Are you defining outpatient  
15      as PHP as well?

16               DR. MCCURDY: No, I am talking about  
17      just outpatient care, plain old-fashioned  
18      outpatient care.

19               MS. COVIE: I apologize, and I am hoping  
20      that Stan addressed that with the fact that we  
21      have some regulatory and statutory issues we deal  
22      with relative to the outpatient reimbursement.

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1               DR. MCCURDY: I understand that, but  
2      those are rules I assume by Congress by statute,  
3      and part of the responsibility of this task force  
4      is to look for issues that Congress can  
5      ameliorate. Those rules did not come from Mount  
6      Sinai, they were made by people in Congress.

7               LCDR WERBEL: Related to that, a  
8      follow-up question, is there a statutory or  
9      regulatory limit to the amount which you can go

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10 above the set rates when you are waiving those

11 fees for the inability to recruit providers in a  
12 particular area?

13 MR. REGENSBURG: I want to tell you  
14 again that the authority that we have to raise  
15 rates, the purpose is not to raise rates to  
16 recruit providers. The purpose of the rate  
17 authority is to review and examine whether we have  
18 a severe access problem, because we want to make  
19 sure that our beneficiaries have access to mental  
20 health outpatient services. So it is not the  
21 purpose to raise rates to recruit providers.

22 LCDR WERBEL: I understand, and I will

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1 stand corrected on the wording of my question, but  
2 is there a statutory or regulatory limit to how  
3 much you could raise that rate to ensure access to  
4 care?

5 MR. REGENSBURG: There is. We need to  
6 be prudent with government dollars.

7 LCDR WERBEL: What is the statutory  
8 limit?

9 MR. REGENSBURG: Are we talking about  
10 network or nonnetwork providers?

11 LCDR WERBEL: Let's start with network  
12 and go to nonnetwork.

13 MR. REGENSBURG: The authority tells us

Washington DC 20061219 TF meeting transcripts FINAL.txt  
14 that we can raise rates up to 15 percent higher  
15 than what we currently have out there for network  
16 providers. For nonnetwork, we would look at a  
17 specific locality to determine whether mental-  
18 health services are not meeting the needs of our  
19 beneficiaries, and that falls under what we call  
20 the TRICARE Standard portion of the program and we  
21 could raise rates to another government program  
22 based on a percentage increase. But we have to

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1 have some kind of guarantee from these providers  
2 that if we raised it 30 percent or whatever that  
3 these providers would be willing to treat our  
4 beneficiaries and not balance bill the beneficiary  
5 also.

6 To answer your question is there a  
7 limit. I think there would be a limit because of  
8 the amount of funding that we have within the  
9 program. The regulatory authority does give us  
10 more flexibility under the locality waiver  
11 authority under the network waiver to increase  
12 rates. So, yes, there is more.

13 DR. MACDERMID: I have a follow-up  
14 question to this, but I would like to ask do you  
15 have some kind of regular procedure that you  
16 implement to monitor any gaps between your  
17 reimbursement rates and the industry standard or

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benchmark your reimbursement rates?

MR. REGENSBURG: I am not sure that we do. We have done some analysis of how our rates compare with other payors, specifically commercial payors, and in recent analysis we have found that

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our rates are competitive to what other commercial payors have established out there.

DR. MACDERMID: We would like to see those data.

LCDR WERBEL: How would you define competitive?

MR. REGENSBURG: I'm sorry?

LCDR WERBEL: How would you define the word competitive?

MR. REGENSBURG: In the last year we have written a couple of reports to Congress on availability of care and I know that mental health was one of the areas that was reviewed. I also understand and believe that the GAO has reviewed this area, this is an area that I believe that they have looked at, and if they have not written updates to their reviews, they are in the process of getting ready to release that information.

COL PEREIRA: It is hard to understand how the rates could be competitive when you are using Medicare as baseline and not some of the

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22 other more standard rates in the industry.

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1 MR. REGENSBURG: I think you may be  
2 concerned that Medicare rates are established on  
3 Medicare data and, hence, what does Medicare  
4 charge data have to do with TRICARE. I am  
5 assuming that that is what you are referring to.

6 DR. MACDERMID: I think what we are  
7 responding to is that we have been on 20 site  
8 visits and on almost every one, providers tell us  
9 that they cannot provide services because they  
10 cannot afford to take the low reimbursement. So  
11 we are trying to understand those anecdotal data  
12 vis-à-vis the empirical data that you are talking  
13 about now. We do not know how to make the picture  
14 fit.

15 MR. REGENSBURG: I think it might be  
16 helpful if we can find out for you if we can  
17 release these reports that were prepared and give  
18 you some documentation and information that way,  
19 because the information and analysis that are in  
20 those reports do not support that there are access  
21 problems for mental-health services. We have not  
22 had any dialogue or any information submitted to

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1 our office stating that there are areas of the  
2 country or pockets of the country that have not  
3 been able to get mental-health services. If that  
4 is the case, we would encourage that kind of  
5 information flow into us so that we can take a  
6 look at. But it has to be documentation that we  
7 can analyze and determine whether there is an  
8 issue where we need to raise rates in order to  
9 satisfy or resolve that issue or problem. We  
10 cannot strictly raise rates based on anecdotal  
11 comments or off-the-cuff comments saying that we  
12 cannot get providers to treat our beneficiaries  
13 because of low rates.

14 COL CAMPISE: What is your procedure for  
15 determining what your access standards are?

16 MS. COVIE: This group cannot really  
17 respond to access standards. Is Mike O'Bar still  
18 there?

19 MR. O'BAR: Referring to the federal  
20 regulation especially for employment, it is 28  
21 days from referral time.

22 COL CAMPISE: What is your process for

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1 determining whether you are meeting those 30- day

MR. O'BAR: There is a whole host of data reporting requirements that our managed care support contractors have to provide to the TRICARE regional offices that address whether or not they are meeting access standards.

COL CAMPISE: One of your regions that we interviewed said that their process was to do a 1 percent survey of all the providers, not even just mental-health providers, but all providers, and based on that 1 percent survey of every health care provider they felt that the access was fine. And that was the same region where we found that there were only child and adolescent psychiatrists available, and one of them had stopped seeing patients a year before and there was a 9-month wait for them to have their initial appointments.

MR. O'BAR: I do not know how to respond to a one-time deal like report like that. All I can tell you is that the reports that the managed care support contractors are providing to the

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TRICARE regional offices show currently that they are consistently meeting the access standards.

COL CAMPISE: Do you know what process they are using to determine that?

MR. O'BAR: Yes, they track the start

6 time, from the time they first get the referral  
7 request until it is fulfilled and report on that  
8 whether or not they are within the standards. By  
9 the way, they pay a monetary penalty if they do  
10 not meet certain performance standard levels.

11 COL CAMPISE: Do they marry that up with  
12 the consults where the people get frustrated from  
13 not being able to get to the provider and just do  
14 not follow-up with an initial appointment?

15 MR. O'BAR: I am not sure how they would  
16 know that if they do not follow-up.

17 COL CAMPISE: It would seem like it  
18 would be important to know.

19 MR. O'BAR: But how would they know  
20 that? If a patient gets a consult but then never  
21 does anything with it, how would that contract  
22 know?

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1 DR. MCCORMICK: May I ask a question  
2 about the partial hospitalization? What  
3 percentage of those partial hospitalization  
4 payments are for substance abuse treatment?

5 DR. MACDERMID: They do not know. They  
6 are going to get us that.

7 MS. COVIE: I think we need to clarify.  
8 If we have some additional data requests, what do  
9 we need to provide and how we get that to you?

10 DR. MCCORMICK: Let me clarify my  
11 question. Somebody did say earlier when I asked  
12 about residential care that none of that was  
13 substance abuse care. Is that correct?

14 MS. COVIE: That is correct.

15 DR. MCCORMICK: I am asking the same  
16 question about partial hospitalization. Do you  
17 know what percentage of that was for substance  
18 abuse care?

19 MS. COVIE: It is not for substance  
20 abuse. Partial again is for psychiatric care.

21 DR. MCCORMICK: I know there is no  
22 straight outpatient benefit for substance abuse.

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1 Are you saying TRICARE provides no substance abuse  
2 care to the wives and children of the armed  
3 services?

4 MS. COVIE: No, that is not the case.  
5 We provide substance abuse care in hospital.  
6 Hospitals can provide inpatient partial and  
7 outpatient. Then we have the specific categories,  
8 the free-standing substance abuse disorder rehab  
9 facilities, and that provide inpatient partial and  
10 outpatient care.

11 DR. MCCORMICK: So you have not  
12 providing us any data on that and this brief is  
13 only on psychiatric care then. I misunderstood.

14 You are not providing any data at all to us on

15 substance abuse care? I am just trying to

16 understand what I am hearing.

17 MS. COVIE: I guess I am not

18 understanding exactly what you are asking, sir.

19 I'm sorry.

20 DR. MCCORMICK: Let me be clear again.

21 For residential care, do you have any data on how

22 much and how many centers there are for substance

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1 abuse residential care? And the same question for

2 substance abuse partial hospitalization care.

3 MS. COVIE: I think I can further

4 address this. RTCs are strictly psychiatric

5 residential treatment for children and

6 adolescents, and that is somebody under 21. We do

7 not collect data on what specialty care they

8 provide, but substance abuse would be a component

9 of that. You would have to have a primary

10 psychiatric disorder to qualify and be admitted to

11 a psychiatric residential treatment center.

12 Psychiatric partial is again for primary

13 psychiatric disorders. Then we have substance

14 abuse which is a separate category.

15 DR. MCCORMICK: How many centers for

16 substance abuse partial and residential do you

17 have throughout the nation?

18 MS. COVIE: Not very many. I would  
19 guess maybe 30. But keep in mind these are just  
20 the free-standing. You can also get substance  
21 abuse care in any authorized hospital.  
22 DR. MCCORMICK: But you do not pay for

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1 outpatient abuse care. Are you talking inpatient  
2 substance abuse care which hardly exists in  
3 hospital? I know of no hospital that provides  
4 that. I am confused. We already have established  
5 in our own minds that you do not cover straight  
6 outpatient substance abuse and you do not cover  
7 intensive outpatient substance abuse. Let me be  
8 very clear. You do not provide just straight  
9 outpatient substance abuse care, you do not  
10 provide by regulation intensive outpatient  
11 substance abuse care, which means that if a family  
12 member has a substance abuse problem, they have to  
13 go to a partial hospitalization or residential  
14 program. I am just trying to get an idea of at  
15 least how far would they have to travel if they  
16 wanted that care.

17 MS. COVIE: I think there are some  
18 invalid assumptions there. We do cover outpatient  
19 substance abuse care. However, by regulation it  
20 is limited to 60 sessions and the reimbursement is  
21 further limited to what we otherwise would pay for

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a group session. So we do cover outpatient

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1 substance abuse care.  
2 DR. MCCORMICK: That is contrary to the  
3 testimony we have had from the TRICARE providers.  
4 MS. COVIE: I do not know where that is  
5 coming from or why that is out there, but by  
6 regulation we cover outpatient substance abuse  
7 care and it is limited to 60 sessions a year.  
8 DR. MACDERMID: Does anyone have any  
9 additional questions? We are close to the end of  
10 our time.  
11 MS. FRYAR: Yes, I do. Just a very  
12 simplistic question. If a provider accepts  
13 Medicare, are they required to accept TRICARE?  
14 MS. COVIE: The answer to that is no,  
15 not for individual professional providers.  
16 DR. MACDERMID: Angela, last word.  
17 COL PEREIRA: Just a point of  
18 clarification. As a licensed clinical social  
19 worker providing treatment on an outpatient basis  
20 I would get paid 75 percent of the Medicare  
21 reimbursement rate? Is that correct?  
22 DR. MACDERMID: No, the physician rate.

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1 COL PEREIRA: No, 75 percent of the  
2 Medicare physician rate. Is that correct?  
3 MR. REGENSBURG: What type of provider  
4 would you be?  
5 COL PEREIRA: A licensed clinical social  
6 worker providing care.  
7 MR. REGENSBURG: For a social worker?  
8 You would fall into the category of nonphysician,  
9 and so the rate that Medicare has established is  
10 75 percent of the rate that would be provided to a  
11 physician.  
12 DR. MACDERMID: Thank you. I believe  
13 then that would conclude this session, and that  
14 concludes our open session for today. General  
15 Kiley, do you have any closing comments to make?  
16 LTG KILEY: I do not. Thank you.  
17 DR. MACDERMID: I want to thank the  
18 speakers for their presentations, and thank  
19 everyone who attended. The open afternoon session  
20 of the meeting is now adjourned. And a special  
21 thank you to our telephonic participants. I am  
22 sorry that we did not introduce ourselves as we

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1 spoke. That must make it a very disjointed

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2 experience, but we thank you nonetheless. And I  
3 hope to see people in the audience again tomorrow  
4 morning at 8:00 when we have another full day.  
5 Thank you very much.  
6 (Whereupon, at 2:00 p.m., the  
7 PROCEEDINGS were adjourned.)  
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